Eligibility, Enrollment, and Renewal: Case Study Findings

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) made significant changes to Medicaid enrollment and renewal processes, with the goal of making the program more efficient; reducing complexity and effort for enrollees and program administrators; and integrating Medicaid with the health insurance exchanges. Many of these approaches were modeled from measures that had previously been successful enrolling children in the State Children's Health Insurance Program (CHIP) and Medicaid, but were not required of states.

The federal government and states had less than four years to establish the rules and infrastructure needed to comply with the new requirements. The initial implementation period was challenging for states; they had to modernize legacy eligibility determination systems, transition to new rules for counting income and household size for some eligibility groups, and enroll the new adult group into Medicaid, while at the same time integrate Medicaid with the developing exchange systems.[1]

To better understand how states implemented these changes and the current status of enrollment and renewal processes, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota School of Public Health. SHADAC examined eligibility, enrollment, and renewal practices for beneficiaries whose income eligibility is determined based on modified adjusted gross income (MAGI) in six states. The synthesis report, as well as the individual case studies can be found on the MACPAC website.

The states that were studied—Arizona, Colorado, Florida, Idaho, New York, and North Carolina—took different approaches to streamlining Medicaid eligibility processes reflecting state-specific policies and priorities as well as the age and capabilities of their eligibility systems. Some states prioritized real-time enrollment and renewal for individuals eligible on the basis of MAGI; other states prioritized eligibility worker involvement in the process. All states focused on transitioning to MAGI-based eligibility determinations and using electronic data sources to verify beneficiary information. In doing so, they also had to balance the need for accurate eligibility determinations with efforts to make Medicaid enrollment as streamlined as possible for beneficiaries.

These six states consistently noted the positive effect of combined online applications on beneficiary access to programs and the efficiencies gained through connections to electronic data sources and business rules software systems. While the states were interested in integrating MAGI-Medicaid with other health or human services programs, updating eligibility rules engines to accommodate different program requirements in one system remained challenging. And although states were streamlining and automating

eligibility determination and enrollment processes and systems, in-person assistance remained in high demand for many individuals.

This brief begins with background on ACA changes to the enrollment and renewal processes. It then discusses the findings from the case studies and the key themes that emerged, before describing the steps states are taking to further improve their programs.

ACA Changes to Medicaid Enrollment and Renewal Processes

Historically, Medicaid enrollment and renewal processes relied on in-person applications and paper documentation to verify eligibility. Eligibility requirements were complex; they included categorical eligibility (based on an individual's inclusion in a specific category such as pregnant women or children) and income eligibility, citizenship and immigration status, and in some cases, a determination of disability or the need for an institutional level of care. States had considerable flexibility in designing and administering many aspects of the process, leading to variation across states and populations.

The ACA's changes to Medicaid enrollment and renewal processes were intended to simplify and streamline those processes for all Medicaid populations.[2] In doing so, there was an expectation that the share of eligible persons able to successfully enroll and retain Medicaid coverage would increase and errors associated with administering complex eligibility rules would decrease (MACPAC 2014). In addition, these provisions were meant to ensure that eligibility and ineligibility determinations would be made more quickly and at less expense. As explained in guidance to states issued by the Centers for Medicare & Medicaid Services (CMS), an efficient enrollment and renewal process includes automating the application and renewal process, integrating it with other public programs, and retiring outdated legacy systems (CMS 2015).

The ACA required states to maximize automation and real-time adjudication of Medicaid and CHIP applications through the use of electronic verification policies, simplified business processes, and the use of multiple modes of application, including online applications. It also gave states broader access to third-party data sources (through the federal data services hub) and required states to use these data to verify eligibility whenever possible, instead of requiring applicants to document their eligibility.[3]

Federal statute and regulations now define a common approach across states for most individuals to apply for, enroll in, and renew eligibility for Medicaid. Even so, states retain flexibility in how they design their applications and conduct eligibility verifications and the processes they use to streamline enrollment and renewal. These common approaches now include:

Income counting. The ACA replaced complex income-counting and disregard rules with a streamlined standard for children, pregnant women, parents, and the new adult group (where applicable) and eliminated use of asset tests for these populations.[4] Use of MAGI and federal tax rules was meant to align Medicaid income counting rules with those used for subsidized exchange coverage.

Applications. The ACA established that individuals use one application for Medicaid, CHIP, and subsidized coverage on the health insurance exchanges. Since 2014, states have been required to use the CMS-developed model application or an approved alternative to determine eligibility for individuals applying on the basis of MAGI.[5] States also have the option of allowing individuals to apply for other public programs, such as the Supplemental Nutrition Assistance Program (SNAP), through the use of a multi-benefit application (CMS 2013).[6] In addition, states may no longer require a face-to-face interview.

Eligibility verification. The ACA shifted the burden of verifying eligibility from applicants to states in order to simplify the process and reduce the number of eligibility errors. States continue to verify citizenship, immigration status, Social Security numbers, and financial eligibility, but must accept self-attestation for pregnancy, and retain the option for self-attestation for other non-financial eligibility criteria (such as age and state residency). States are required to rely on electronic data sources to the greatest extent possible when verifying eligibility. If data cannot be obtained electronically or are not reasonably compatible with the applicant's attestation, the state must ask for additional information, which could include paper documentation.

Redeterminations. Redeterminations are designed to account for changes in an individual's circumstances, as well as catch errors in initial eligibility determinations. Applicants are responsible for providing accurate information and reporting any changes, such as changes in income, which may affect eligibility as they occur. For those eligible on the basis of MAGI, states renew eligibility no more than once every 12 months. To renew coverage, states must first attempt to confirm ongoing eligibility based on information available from a beneficiary's account or other available data sources (also known as an administrative or ex parte renewal). If the state cannot renew eligibility using available information, it provides a prepopulated renewal form for the beneficiary to complete. States also must consider whether an individual is eligible through other eligibility pathways prior to terminating eligibility.

Eligibility processing and coordination. In processing applications, states must meet federal timeliness and performance standards and make eligibility determinations "promptly and without undue delay" (42 CFR 435.912). States are expected to establish their own timeliness and performance standards, but must meet federal requirements for completing eligibility determinations within 90 days for those applying on the basis of disability and within 45 days for all others. States must also provide three months of retroactive coverage if an individual received services and would have been eligible at the time.

Case Study Findings

The study conducted for MACPAC by SHADAC assessed auto-enrollment and auto-renewal practices, the use of electronic data sources for verification, and the degree of integration with populations who were eligible for Medicaid through non-MAGI pathways and other public benefit programs. It focused on the experiences of six states: Arizona, Colorado, Florida, Idaho, New York, and North Carolina. These states were selected based on a literature scan and discussions with MACPAC and external experts. They represented diversity across a range of characteristics, including program size, exchange type, adoption of the ACA Medicaid expansion, current enrollment and renewal practices, geography, and political climate.

In May and June of 2018, SHADAC conducted semi-structured phone interviews with 48 individuals in these states, including Medicaid eligibility and policy staff, information technology staff, other state and local agency staff, state exchange staff, and advocacy organizations. In advance of telephone interviews, SHADAC also confirmed information pertaining to each state's Medicaid program and eligibility systems with key state staff.

The states studied approached streamlining their Medicaid eligibility processes differently, although all made strides toward the goal of simplifying the application, enrollment, and renewal process for individuals and state administrators. This section describes each state's approach.

Arizona

Arizona offers a single streamlined application process that currently supports Medicaid, CHIP, SNAP, and Temporary Assistance for Needy Families (TANF). MAGI-eligible populations most frequently apply online, whether independently or with the help of a state worker or an enrollment assister at one of more than 200 community partner organizations throughout the state.

Although the application is combined across health programs (i.e., MAGI Medicaid and CHIP) and non-health programs (i.e., SNAP and TANF), the eligibility system is shared only by health programs. Application information for Medicaid, whether originated on paper or electronically, is processed using a modular, cloud-based eligibility determination system, and application information regarding SNAP and TANF is sent to a 30-year-old legacy mainframe eligibility system.

Most eligibility factors such as income, residency, age, Social Security number, citizenship, and immigration status are verified in real-time through data linkages between the eligibility system and electronic data sources from the federal data services hub and Arizona's own state hub. Respondents were uniformly positive about the ability to verify eligibility factors using these sources; however, one respondent noted the limitations of sharing data across programs. Specifically, Social Security Administration data can only be used to verify factors for SNAP or TANF if the applicant is also applying for Medicaid.

Respondents in Arizona defined automated eligibility determination as real-time, eligibility determination at application, that requires no touch from a state worker. The state achieves a 49 percent rate of automated eligibility at application for people who are eligible for Medicaid through MAGI; respondents noted that the key facilitators are the applicant having income that can be verified electronically, the existence of a robust business rules engine (to automate the eligibility rules), and interfaces with electronic data sources for verification purposes.

In Arizona, approximately 55 percent of Medicaid cases, and 60 percent to 65 percent of MAGI Medicaid cases in particular, were being auto-renewed (a no-touch, automated renewal) at the time of the interview. The eligibility system checks the relevant electronic data sources at the federal and state hubs and 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 a pre-populated form to the beneficiary showing the information used to complete the renewal, stating that the beneficiary was found to remain

eligible, and asks the beneficiary to contact the state if any of the listed information has changed. Respondents noted that beneficiaries often struggled to understand the prepopulated renewal forms and frequently sent them back when no response was required, adding to the state's workload unnecessarily.

State officials in Arizona indicated that they had expected to integrate eligibility systems for MAGI Medicaid with human services programs—namely SNAP and TANF—by July 2017. However, as noted above, while SNAP and TANF share the combined application with MAGI Medicaid in Arizona, SNAP and TANF eligibility determinations have not yet been integrated within the eligibility system.

Colorado

Colorado had plans predating the ACA for horizontal integration of Medicaid and other health and human services programs and developed a shared eligibility system, a combined online application, and co-located staff. The single, streamlined application process currently supports Medicaid, CHIP, health insurance coverage available through the exchange, and a variety of human services programs. People seeking Medicaid more frequently apply using the online application, although a combined paper application also continues to be commonly used at county human services departments.

Application information for Medicaid, whether it originates on paper or electronically, is fed into a shared eligibility system used for Medicaid, exchange coverage, and other public assistance programs. While the online application supports 13 programs, the shared eligibility system only determines eligibility for a subset of these programs, including Medicaid, CHIP, exchange, SNAP, TANF, and child care assistance.

To the extent possible under the ACA, Colorado allows beneficiaries to self-attest eligibility factors and verifies beneficiary income information during a post-eligibility determination process. To verify income, the state uses the Income and Eligibility Verification System (IEVS), a state system housing data that includes earned income, unearned income, and unemployment compensation. However, income information in IEVS is not available until the quarter following application.

At least 75 percent of cases in Colorado are auto-enrolled, meaning that eligibility is determined in real-time without beneficiary or worker involvement. Respondents suggested that there were several key factors that contributed to auto-enrollment of MAGI Medicaid populations, including the online application, automated rules, interfaces with electronic data sources for verification purposes, and post-eligibility verification of income.

Auto-renewal of MAGI Medicaid eligibility in the state occurs in two ways. The first, known as medical cases, refers to no-touch renewal for individuals with medical coverage only. These members receive a prepopulated form that contains information that was either previously provided by the beneficiary (such as at application or when updating a change) or populated through state data interfaces. The second type of auto-renewal, known as ex parte renewals, is for financial cases (individual receives both medical and non-medical support, e.g., SNAP). Medicaid renewal for these cases could be initiated automatically based on the SNAP renewal timing. Facilitators of timely and low-touch renewals noted by stakeholders included the electronic interfaces in the shared eligibility system, the ability to verify eligibility factors such as income at the renewal date of another program, such as SNAP, and the prepopulated form.

Among the challenges commonly cited with the state's integration of MAGI Medicaid and other programs were the difficulties updating the rules engine to accommodate different program requirements, which are often stricter than MAGI Medicaid, in one system. Respondents also noted the substantial costs of maintaining and enhancing a shared eligibility system. However, agreed that the benefits of a shared eligibility system, especially in terms of the beneficiary experience, outweighed the costs. Both state and community stakeholders articulated the value of having a system capable of processing eligibility determination for more than one program, as multiple agencies were able to use and financially benefit from the same technology.

Florida

Florida has long been committed to shared services for public assistance programs. The Department of Children and Families (DCF) is the state agency responsible for making eligibility determinations for several health and human services programs as well as maintaining the state's shared eligibility system, which was in place before the ACA.[7] In 2005, Florida was one of the first states to launch an online combined application for Medicaid and other human services programs, which the state revised in anticipation of ACA implementation. Florida's legacy shared eligibility system, however, has not undergone a major overhaul since 2004 (although system updates occur monthly).

There are three online applications for Medicaid in Florida, including a combined application for medical assistance (including non-MAGI Medicaid), SNAP, and TANF; a health-only application; and the federal exchange. Application information for Florida Medicaid, whether it originates on paper or electronically through any application, flows through approximately 26 systems, including a shared legacy mainframe eligibility system and web-based systems, applications, and tools. To comply with ACA requirements, the state developed a separate platform that sits alongside the legacy system and facilitates real-time eligibility determinations for Medicaid and CHIP applicants, while the legacy system continues to determine eligibility for SNAP and TANF.

Florida accepts self-attestation for many eligibility factors such as age, residency, and household composition, and uses both federal and state data sources to verify income. No-touch, real-time eligibility determinations are done for a subset of MAGI Medicaid applicants, typically MAGI Medicaid-only cases but not households that are also eligible for other public assistance programs, for which electronic data sources can successfully verify income, citizenship, and identity. More often, the state processes partial-touch eligibility determinations, meaning cases require worker involvement (for example, confirming income by checking interfaces with other data sources and imaged documents) prior to approving or denying eligibility. DCF is able to process up to 45 percent of determinations in 24 hours and up to 65 percent of determinations within one week.

The ACA also prompted DCF to design a new workflow for Medicaid auto-redetermination in Florida, referred to as auto-renewal. Auto-renewal of MAGI Medicaid cases refers to a low-touch process in which DCF verifies eligibility using electronic data sources. After workers have reviewed and approved renewal, DCF notifies individuals that their cases are being renewed. Up to 50 percent of MAGI Medicaid cases are auto-renewed. In the event that Medicaid cases cannot be renewed using existing information, individuals

are required to re-enter income information at renewal (rather than verify existing data on prepopulated forms).

Auto-renewals for combined cases (i.e., individuals receiving both health and non-health assistance) are conducted differently. Florida extends Medicaid for 12 months with SNAP recertification if income reported at an individual's six-month SNAP recertification demonstrates continued eligibility for Medicaid (although Medicaid is not terminated if an individual's SNAP assistance is not renewed). There were 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 individuals could lose SNAP coverage. On the other hand, beneficiaries might perceive that their Medicaid coverage was at risk when their SNAP eligibility was being reviewed.

Idaho

Idaho has a history of conducting eligibility determinations for health and non-health programs in an integrated way that predates the ACA. Respondents commented that housing the application, eligibility processes, and customer-facing tools to support eligibility determination all within one bureau allows the state to have excellent customer service as well as low administrative costs. In addition, one online application is used for all health coverage programs and the state uses a single, horizontally integrated eligibility system that supports all health and many non-health eligibility determinations. Respondents indicated that the state's commitment to supporting an integrated eligibility system with a robust rules engine was critical to achieving the horizontal integration of MAGI Medicaid with other health and human services programs.

In Idaho, applications are primarily submitted in person; only 20 percent of applications are submitted online, 30 percent are submitted by phone, and 50 percent are submitted another way, including in person (Brooks et al. 2018). Respondents described the state approach to the application process as prioritizing in-person or phone-based application support. One respondent surmised that this high-touch approach works because Idaho has a relatively small Medicaid program; 268,000 individuals in April 2018.

Both the paper and online application serve as a single, combined application for all health care programs, including MAGI and non-MAGI Medicaid, CHIP, exchange plans, the Medicare Savings Program, and waiver programs.[8] Individuals interested in receiving non-health benefits such as SNAP or TANF must contact the Department of Welfare directly to apply for services, which respondents cited as the primary reason for promoting in-person and phone-based applications. However, once beneficiaries are enrolled in a non-health program, they can set-up an account and view or manage certain aspects of their account, even though they are not able to apply online.

All application information is submitted to the state's single, state-wide, web-based integrated eligibility system for Medicaid and human service programs such as SNAP, TANF, and child care. Implemented in 2009, this system replaced a mainframe system in existence since 1985. With the passage of the ACA, the shared eligibility system was enhanced to determine eligibility for all health programs, including subsidized coverage on the exchange.

Idaho relies on many electronic eligibility verification processes that pre-dated the ACA, in addition to the federal data services hub. For example, the state received a waiver from CMS to use an existing connection with the Social Security Administration to conduct identity proofing to support more timely eligibility determinations as well as allow the information to be used to support eligibility determinations for other programs, such as SNAP. Idaho uses multiple state data sources to supplement federal income tax information to verify income, including quarterly wage data, which were also described as facilitating more accurate and timely determinations. Data are electronically verified using a state-developed aggregator that pulls data from various sources into a single worker dashboard. While many aspects of the eligibility verification process are automated and draw on electronic data, every Medicaid enrollment requires an action by an eligibility worker. Even so, 50 to 75 percent of MAGI Medicaid determinations are made within 24 hours (Brooks et al. 2018).

Roughly 90 percent of Medicaid renewals were described as no-touch. Idaho has achieved this high auto-renewal rate by creating different workflows and verification requirements for three different types of households (e.g., families with multiple types of coverage) and by aligning the timing of re-evaluations for all health care programs to be consistent with open-enrollment. (According to respondents, the state is moving away from aligned renewal timing to ease workloads.)

New York

In implementing the ACA, New York made a decision to administer all health insurance programs under a single state agency, the Department of Health (DOH). In addition, state legislation passed in 2012 shifted the administration of Medicaid, including eligibility and enrollment decisions, from county and New York City governments to the DOH (NYSOH 2017). This transition is still in progress. Currently, eligibility determinations, enrollment, and renewal for programs that use MAGI-based eligibility criteria are conducted statewide, through the online application, by the DOH's Office of Health Insurance Programs. This includes MAGI Medicaid, CHIP, the Basic Health Plan (BHP), and exchange plan coverage. (The state refers to all of these programs as Marketplace Programs.)[9] For programs where non-MAGI eligibility rules still apply, eligibility, enrollment, and renewal are conducted by local departments of social services. Eligibility for other non-health public assistance programs, such as TANF, SNAP, and home energy assistance, is also assessed by local departments of social services.

The online application is the most commonly used application mode. However, the vast majority (77 percent) of beneficiaries seek in-person enrollment assistance from a navigator, broker, or certified application counselor, and another 7 percent seek assistance over the phone. All applications receiving assistance are submitted through the exchange's online system. Fewer than 20 percent of those enrolling in Medicaid, CHIP, and BHP enroll online through the exchange without assistance (NYSOH 2018). Respondents described the assister community as "well-connected" and supported by state government, noting that this fosters high-quality enrollment assistance.

New York verifies eligibility electronically for Marketplace Programs, leveraging multiple electronic data sources, including sources available through the federal data services hub as well as state sources. Paper documentation is only required when an electronic data source is not reasonably compatible with the information provided by or on behalf of an individual.

In New York, most eligibility determinations are made based on automated rules and data verification processes built into the system, as applied to the information provided by the consumer. Applicants who need eligibility determinations for non-MAGI eligibility categories are referred out of the system to the local departments of social services. More than 90 percent of Marketplace Program-eligible individuals experience automated eligibility determinations. Interviewees credited the shared eligibility system as a key facilitator of automated eligibility, supporting integration across health programs.

At application, beneficiaries are asked to give permission for the state to use electronic data for redeterminations, and for those who agree, between 25 percent and 50 percent receive a no-touch administrative renewal (Brooks et al. 2018). When administrative renewal is unsuccessful, it is often because the beneficiary has not given permission to verify eligibility requirements against electronic data sources or beneficiary information (typically income) cannot be verified electronically. In such cases, beneficiaries must return and update their accounts within the required time frame in order to renew eligibility and coverage for the upcoming year.

North Carolina

North Carolina agencies focused on the horizontal integration of Medicaid and other health and human services programs prior to the ACA. For example, the state worked to align program eligibility requirements in order to develop a shared eligibility system and combined online application. However, respondents commented that conflicting federal policies around program requirements (e.g., the requirement for a face-to-face eligibility interview for TANF but not for Medicaid) presented an obstacle to true horizontal integration.

North Carolina offers a combined application that currently supports Medicaid, CHIP, and SNAP. While the state has a dynamic, online application (applicants choose which program they want to be screened for first, either Medicaid or SNAP, and are then given the option to answer additional remaining screening questions for the other program), the most common way MAGI-eligible populations apply for Medicaid is in person at county Department of Social Services (DSS) offices. However, not all counties across the state offer a combined application for in-person applicants. Some, especially smaller counties, still use program-specific applications, and staff are divided by program-specific duties.

Application information for Medicaid is fed into a shared eligibility system, which includes Medicaid and several other public assistance programs including SNAP, TANF, child care, and refugee assistance. Although multiple programs are supported by the shared eligibility system, it 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. While caseworkers can see information across platforms, and demographic information updated in one system is automatically updated in the other, program-specific information (such as income) can only be updated in its respective platform.

North Carolina generally does not accept self-attestation. The state uses electronic data to assess potential eligibility for MAGI Medicaid for several eligibility factors including income, residency, Social Security number, and citizenship. Two forms of verification are required for state residency. Some factors

are verified through state-built interfaces that automatically facilitate data transfers between the eligibility system and the external data sources, while others require a county worker to manually view elements stored in the external data source.

Medicaid and CHIP are state-supervised, but are administered by North Carolina's 100 county DSS offices. This means that county staff are responsible for eligibility determination, enrollment, and renewal of Medicaid applications in their respective counties. There currently is no automated enrollment for applicants who qualify for Medicaid through MAGI at application. While the eligibility system performs data checks and makes a preliminary assessment, a county worker must verify and approve each Medicaid enrollment. The state reports that its average Medicaid determination processing time (for both MAGI and non-MAGI Medicaid cases) is 37 days (NC SL § 11H.21 2017).

Renewal of MAGI Medicaid eligibility cases is considered a low-touch ex parte process in which a case worker initiates the electronic verification of data through the eligibility system, leveraging information from external sources and other programs (such as SNAP) as needed. A pre-populated form is only sent to a beneficiary when a caseworker is unable to determine eligibility through electronic data matches and information in other records.

Key Themes across States

As states worked to streamline the eligibility and enrollment process while maintaining the accuracy of determinations, they took different approaches depending upon existing policies, program priorities, and system capabilities. Despite these differences, 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 reduce burden, but backend eligibility systems were complicated to maintain. Across the states that were studied, respondents said that their combined online applications supported greater access to coverage and reduced beneficiary burden. With a single application, individuals could submit required information just once, rather than having to submit the same information multiple times through different applications. The combined application also helped raise applicant awareness of other benefits for which they may have been eligible.

Respondents acknowledged that while their application pathways, systems, and processes were integrated from the customer point of view, the backend eligibility systems were 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 helped to reduce or shift workloads for eligibility staff, especially for those serving individuals who received benefits from multiple programs.

Electronic data interfaces facilitated high rates of real-time eligibility determinations, auto-renewal, and reduced churn. Respondents all agreed that system connections with electronic data sources (state, federal, and proprietary) 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 data linkage capabilities for data to populate the eligibility system. In addition, these interfaces allowed for more timely notifications to counties. In county-administered Medicaid programs, workers could process cases that were also eligible for other benefits more quickly. Assisters in multiple states also praised the online application together with the integrated eligibility system and use of electronic data to verify information for speeding the processing time. However, despite robust rules and electronic use of data, verifying income remains one of the biggest challenges states face, as some beneficiaries (particularly those with unstable incomes) are required to provide additional documentation. 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 promoting continuity of care.

Robust rules engines were critical, but workers still needed 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 supporting streamlined eligibility determinations. Several respondents also explained that the rules engine supports a quality control step as well, whereby workers can review with individuals how the information they entered was processed and make corrections if needed. In addition, some respondents felt that state's rules-based processes have helped reduce inaccurate Medicaid determinations. In addition to facilitating a faster, more efficient process, a robust rules engine was seen as supporting better customer service. Business rules allowed eligibility workers to focus on the consumer and their specific situation, not the minutia of program rules. At the same time, however, respondents felt policy knowledge was still important for eligibility workers in order to assess whether the individual entered information correctly and whether the system made an accurate eligibility determination.

Complex and varied program rules remained a challenge for integration of MAGI Medicaid and other programs. Updating eligibility rules engines to accommodate different program requirements in one system remained challenging, as other programs may have had different income counting rules or stricter verification requirements, such as an 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. Several states structured online applications so that they were dynamic, meaning that additional relevant questions appeared depending on the information already entered; other states struggled with combining application information.

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 remained 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 came to state agency or community assister offices typically because they lacked computer access, had difficulty understanding the application questions, needed help interpreting notices, or needed assistance with documentation.

Looking Forward

State efforts to accurately and efficiently enroll and renew Medicaid-eligible populations continue to evolve. When the ACA was enacted in 2010, states varied widely in their Medicaid eligibility and enrollment practices, but all states initially faced challenges around ACA implementation, including implementing simplified eligibility rules and making decisions about integrated and modernized systems. States have made a range of choices regarding ACA implementation and they are still exploring approaches to increase efficiency and improve consumer experience.

Accommodating Medicaid policy changes. 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 expiration of the Office of Management and Budget Circular A-87 cost allocation waiver on December 31, 2018. 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. In addition, there is a $26 million reduction in CMS grant funding to the ACA Navigator Program for plan year 2019, and the upcoming statutory reduction in the federal medical assistance percentage (FMAP) for Medicaid expansion populations.

Efforts to improve beneficiary correspondence. Four of the study states reported beneficiary confusion regarding correspondence about eligibility determination and renewal, and three of these states reported plans to either improve readability, allow the notices to be more case-specific, or provide assisters with access to notices.

Investment of staff resources and funding to improve application and eligibility systems. All six states are working to advance their application platforms to increase usability for individuals. Additionally, all were in the process of enhancing their eligibility systems through integration across health and non-health programs and moving away from legacy mainframe systems to rules-based systems and modular, cloud-based platforms.

Endnotes

[1] In some states, implementation was delayed further by lawsuits regarding the constitutionality of the ACA, which were not settled until after the law took effect.

[2] Processes may differ for individuals age 65 and older and those with disabilities. For example, states may continue to require asset tests and face-to-face interviews for individuals applying for coverage under non-MAGI rules. As the focus of this study was on the MAGI population, those distinctions are not discussed here, but are detailed in MACPAC's fact sheet: *Federal Requirements and State Options: Enrollment and Renewal Procedures*.

[3] 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 state Medicaid agencies. Data sources provided through the hub include those from relevant federal agencies such as the Social Security Administration, the U.S.

Department of Homeland Security, and the Internal Revenue Service, as well as proprietary data sources, such as the Work Number.

[4] MAGI methods do not apply to individuals whose eligibility is determined on the basis of age or disability; those whose eligibility for Medicaid does not require a Medicaid determination of income, such as individuals receiving Supplemental Security Income or Title IV-E child welfare assistance; those in need of long-term services and supports; and certain individuals applying for assistance with Medicare cost sharing or through medically needy pathways. For these populations, states continue to use the financial methodologies and requirements of the cash assistance program most closely related to the individual's status that were in place prior to enactment of the ACA.

[5] CMS published a model application on April 30, 2013 for state review along with guidance allowing states to use the model or develop an alternative application for approval (CMS 2013).

[6] States can choose to use a separate application for the people whose eligibility is not determined using MAGI methods or a combination of the single, streamlined application and supplemental forms necessary to collect the information to determine eligibility for non-MAGI pathways. The single, streamlined application includes some high-level screening questions to identify disability or the need for long-term services and supports, but it does not capture all the information needed to conduct a non-MAGI eligibility determination (CMS 2017). For example, because enrollees who qualify for Medicaid through a non-MAGI may be subject to an asset test and need a disability determination, additional information may be required on the application in order to make an eligibility determination.

[7] The Department of Children and Families, a separate, sister agency from the agency that administers Medicaid (the Agency for Health Care Administration, or AHCA), conducts eligibility determinations for Medicaid and other public benefits, including SNAP and TANF.

[8] Under the Medicare Savings Programs, state Medicaid programs are required to help pay for Medicare premiums and in some cases, Medicare cost sharing for low-income adults over age 65 and adults with disabilities.

[9] The Basic Health Plan allows states to provide coverage to individuals with incomes between 133 and 200 percent FPL, who would otherwise be eligible to purchase an exchange plan and to individuals with incomes below 138 percent FPL who are lawfully present in the United States, but do not qualify for Medicaid due to their immigration status.

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