Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study

CASE STUDY SUMMARY REPORT – FLORIDA

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Medicaid and CHIP Payment and Access Commission (MACPAC)

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STATE HEALTH ACCESS DATA ASSISTANCE CENTER

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INTRODUCTION

Over the last decade, simplifying and streamlining state Medicaid enrollment and renewal processes and systems have been a priority for state agencies. These changes were accelerated with the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA called for enhancements to Medicaid, including the implementation of revised eligibility rules, a single streamlined application, and use of technology to verify and exchange data in support of near real-time eligibility determinations.[1] Additionally, the Centers for Medicare & Medicaid Services (CMS) and other federal agencies provided states with guidance and incentives to modernize and integrate eligibility systems in order to efficiently enroll Medicaid-eligible individuals.

As the legislative branch agency charged with advising Congress on Medicaid and the Children's Health Insurance Program (CHIP), the Medicaid and CHIP Payment and Access Commission (MACPAC) sought to better understand the post-ACA status of state systems and processes used to support 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 in selected states of current Medicaid eligibility, enrollment, and renewal practices, and the extent to which they are achieving desired goals (such as program efficiency and simplified beneficiary experience).

A case study approach was used to collect data regarding the state of practices associated with enrolling the Medicaid population for which income eligibility is determined based on Modified Adjusted Gross Income (MAGI). Specifically, we assessed 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. Case studies 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.

The study focused on six 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. States were selected based on a literature scan as well as discussions with MACPAC and external experts and represented diversity across a range of characteristics including Medicaid program size, exchange type, adoption of the ACA Medicaid expansion, current enrollment and renewal practices, geography, and political climate.

This case study summary report includes findings from Florida based on: telephone discussions with twelve key informants conducted in May through early July of 2018; a review of publicly available and state-provided documents (e.g., verification plans submitted to CMS); and data collected from state agencies in advance of telephone discussions on the organization of the state's Medicaid program, eligibility system, and other information technology resources to support MAGI Medicaid eligibility determination. (See the Appendix for a copy of the data collection form used to gather information in advance of telephone interviews.) Key informants in Florida included leadership of the Medicaid agency—the Agency for Health Care Administration—as well as policy, quality, systems, and information technology staff at the Department of Children and Families responsible for determining eligibility for Medicaid and other human service programs in the state. We also spoke with two organizations with different perspectives on enrollment assistance in the state.

[1] According to CMS guidance, real time refers to no delay between submission of a complete and verifiable application and the response to the applicant. (CMS n.d.)

The case study begins with an overview of Medicaid in Florida and a high-level description of how individuals apply and how their eligibility is determined for MAGI Medicaid populations. Included in this overview section are case study findings related to the approaches Florida is taking to streamline enrollment and renewal for MAGI Medicaid populations. Next, we present key themes, as identified by key informants, related to Medicaid program and beneficiary experiences, including successes and challenges of Florida's approaches. Lastly, we summarize ongoing issues and future plans in the study state to further simplify and streamline enrollment.

STRUCTURE OF MAGI MEDICAID ENROLLMENT AND RENEWAL

The Agency for Health Care Administration (AHCA) operates Florida's Medicaid program and the Florida Healthy Kids Corporation administers the State Children's Health Insurance Program (CHIP).[2] As of April 2018, total Medicaid and CHIP enrollment was 4.3 million individuals or 20 percent of the state's population—among the largest Medicaid populations in the nation (CMS 2018, Census 2017). Enrollment of children in Medicaid as of March 2018 was 2.5 million (CMS 2018a). The majority (92 percent) of Medicaid and CHIP beneficiaries in Florida receive services through its managed care system (KFF 2017).

Eligibility for Medicaid and CHIP is determined by a separate state agency, the Department of Children and Families (DCF). When asked about housing Medicaid eligibility determination separate from the rest of Medicaid program administration, state respondents pointed to DCF as the "eligibility experts." For years, DCF has served as the single state agency overseeing eligibility determination for Medicaid, CHIP, and other public assistance programs in the state, including Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Children not eligible for Medicaid (due to income at application or a reported change later) are referred to the CHIP program or to the federal health insurance exchange. The state elected to use the federal exchange to assess Medicaid and CHIP eligibility, which then transfers the account to DCF for final determination.

Table 1 provides an overview of Family-Related Medicaid and CHIP eligibility and Advanced Premium Tax Credit (APTC) thresholds in the state. Adults eligible for Medicaid include parents and caretaker relatives and children age 19 to 21. In addition to these populations, pregnant women and children are eligible for Medicaid up to varying income levels. Florida adopted 12-month continuous Medicaid eligibility for children under age five, and six-month continuous coverage for children age five to 19 (Florida KidCare 2017). According to a recent brief, a small percentage of children in the state receive coverage through the federal exchange (Alker & Wagnerman 2017).

[2] CHIP includes HealthyKids (children 5–18 years), MediKids (children 1–4 years), and the Children's Medicaid Services (CMS) Managed Care Plan (children from birth through 19 years with special health care needs).

Table 1. Florida Family-Related Medical Assistance Eligibility and Advanced Premium Tax Credit (APTC) Thresholds, by Coverage Group, 2018

Coverage Group	100% FPL	200% FPL	300% FPL	400% FPL
Pregnant Women	190% (Medicaid)		> 190%–400% (APTC)	
Infants (< 1 year)	200% (Medicaid)		> 200%–400% (APTC)	
Children (Age 1–18)	133% (Medicaid)	>133%–200+% (CHIP)	>200+%–400% (APTC)	
Parents, Caretaker Relatives, Children (Age 19–20)	33%	>33%–400% (APTC)		
Single Adults	0%–100% No coverage available	>100%–400% (APTC)		

Sources: Brooks et al. 2018; FL DCF 2018; FL 2017; FL DCF 2016.

Notes: Eligibility levels are reported as percentage of the Federal Poverty Level (FPL). Percentages include the five percentage point disregard established under the ACA, which can be applied to eligibility determination for MAGI Medicaid individuals. The table is limited to primary eligibility categories defined by the state as Family-Related Medicaid. Florida State Children's Health Insurance Programs (CHIP), (i.e., Healthy Kids, MediKids, and Children's Medicaid Services [CMS]), include premium payments. Both MediKids and Florida Healthy Kids include full-pay programs for those over 200 FPL. CMS includes children birth to 19 years. Medicaid eligibility for parents is the upper income limit for a family of three.

Application options and eligibility systems

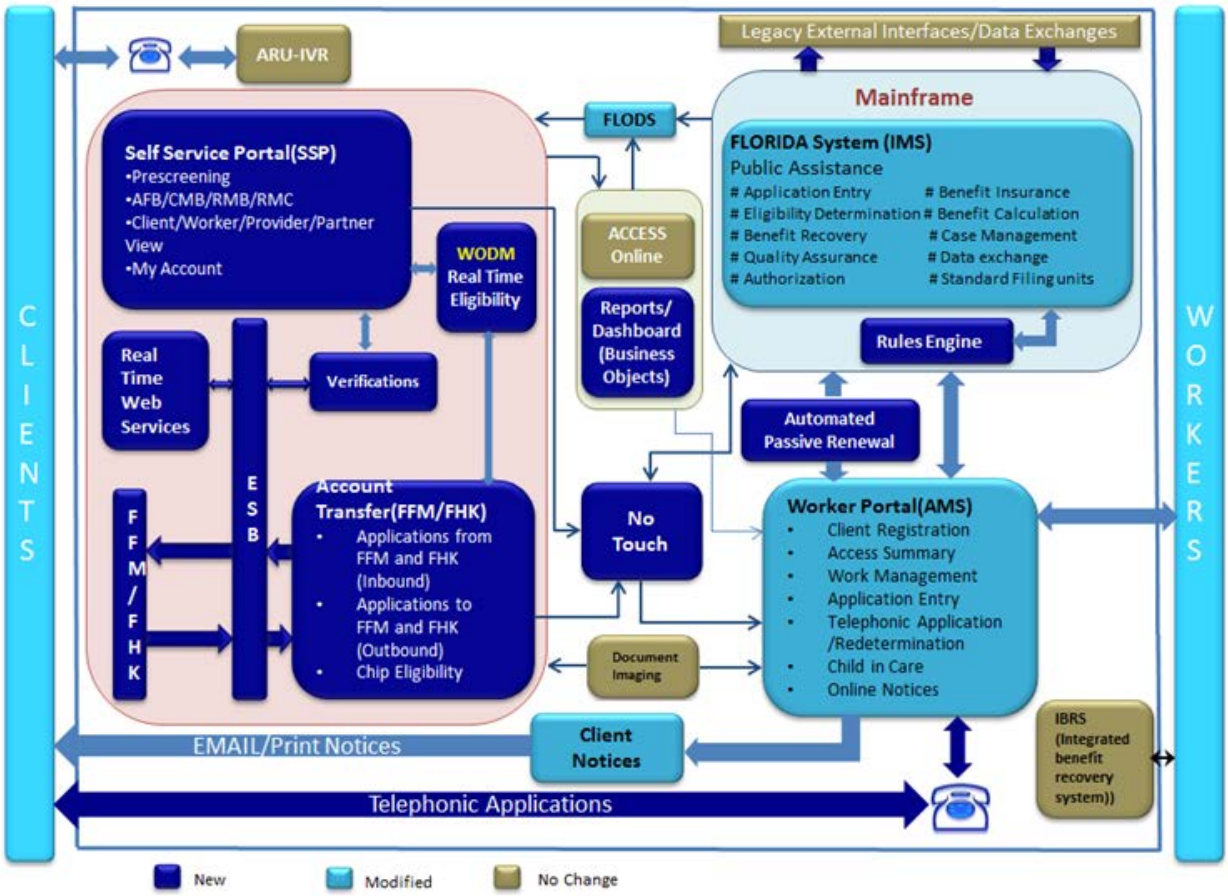
Staff from both AHCA and DCF referred to Florida offering a "one-stop shop" application process that supports health and non-health programs. Consistent with federal law, applications can be submitted several ways: in person at DCF customer service or DCF community partner sites, mail, fax, telephone, and online through the state's online application pathways or the federal exchange (healthcare.gov). According to data from DCF, the state processed an average of 217,000 applications each month between January and June of 2018. Assistance is provided by several entities, including DCF local customer service centers, DCF community partners, CMS navigator grantees, certified application counselors, and other enrollment assisters (CMS 2017).[3]

There are three online applications for Medicaid in Florida: ACCESS (a DCF combined application); Family-Related Medical Assistance Application (a health-only application common to both DCF and Florida HealthyKids); and healthcare.gov. ACCESS (established well before the ACA and maintained by DCF) is an online, combined application for medical assistance (MAGI Medicaid, non-MAGI Medicaid, and CHIP), food assistance (i.e., SNAP), and temporary cash assistance (i.e., TANF). The application tailors itself dynamically based on the responses of the applicant. For example, if an applicant applies for just one program, ACCESS will display only what is relevant to that particular program. Applicants need to set up a MyACCESS account in order to proceed with this application. (This portal is depicted as the ACCESS Self-Service Portal on the diagram of the ACCESS Florida System Architecture in **Exhibit 1** below. This customer facing-portal is integrated with a worker portal known as ACCESS Management System [AMS], also shown on the exhibit.)

DCF also supports a health-only online application pathway, which includes Medicaid, CHIP, and the federal exchange. This application is housed on the HealthyKids website. According to DCF, "the CHIP agency…[has] an application on their site and individuals can apply for Medicaid there or they can apply for CHIP. And if only for Medicaid…the account is transferred to us. That is no different than the way it is done at the federal level when individuals apply on the marketplace [exchange] and they are requesting a full determination for Medicaid or they are applying for CHIP and the account is transferred to the state."

[3] DCF community partners are known as the Automated Community Connection to Economic Self-Sufficiency (ACCESS) Community Partner Network, which includes approximately 3,000 organizations charged with helping individuals access SNAP, Medicaid, Refugee Assistance, or Temporary Cash Assistance.

Exhibit 1. ACCESS Florida System Architecture



Source: FL DCF Office of Economic Self-Sufficiency.
Note: Legend shading indicates changes for Patient Protection and Affordable Care Act (ACA) implementation.

Application information for Florida Medicaid, whether it originates on paper or electronically through any application, flows through the ACCESS Florida System Architecture. This is a complex set of approximately 26 systems, including a shared legacy mainframe eligibility system and web-based systems, applications, and tools (see **Exhibit 1**). The FLORIDA System, built on a mainframe platform in the early 1990s, serves as the official or system of record for Medicaid, SNAP, and TANF. In 2013, to comply with ACA requirements, the state developed a separate open platform (shown on the left side of **Exhibit 1**) that sits alongside the legacy system and facilitates real-time eligibility determinations for 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 mainframe system continues to determine eligibility for SNAP and TANF.

The 2013 modernization project included the development of a new business rule engine on the open platform to make eligibility determinations in Medicaid (initially MAGI Medicaid and soon after all Medicaid) and HealthyKids. One respondent explained, "The only portal to do that electronic verification is through Medicaid [DCF]. So even if somebody came in on the CHIP app, they're clearly CHIP eligible, that income eligibility through the electronic portal is verified through DCF's system…then passed back to CHIP for processing of additional documentation before final determination." The modernized platform also supports account transfers among Medicaid, CHIP, and exchange products.

Because DCF's FLORIDA System serves as the official record of eligibility for Medicaid applicants, any changes to characteristics of applicants, including mailing addresses, must be provided by beneficiaries to DCF either in person, by phone, or via the MyACCESS self-service portal. However, it was reported that beneficiaries inform their managed care plans or AHCA of address changes, and there is not a seamless way to share this information across organizations. One respondent explained, "This becomes problematic for notices generated by DCF," which are not always received by beneficiaries who have moved but have not updated their addresses directly with DCF.

The ACCESS Florida System Architecture sends batch eligibility files nightly to the state's Medicaid Management Information System (MMIS) housed at AHCA. AHCA and its contractors process enrollment, including determination of whether a beneficiary is eligible for mandatory or voluntary managed care enrollment or fee-for-service enrollment.[4] According to one respondent, approximately 40 to 60 percent of cases are auto-assigned, or mandatorily enrolled into a managed care plan after their eligibility determination has been made, each year. AHCA employs Choice Counselors to assist customers with both managed medical assistance and managed long term care services in the state.

Electronic verification for MAGI Medicaid beneficiaries

State interfaces with electronic data sources, business rules engines, and worker processes move an application through to "authorization," which is how one state agency referred to eligibility determination. To the extent possible under the law, Florida allows beneficiaries to self-attest many factors of eligibility such as age, residency, and household composition. If self-attested information is inconsistent with information available to DCF from other sources, the state requests reasonable explanations before paper documentation.

Income is accepted if the self-attested income is reasonably compatible (within 10 percent) with electronic data (state wage data is considered more accurate and up-to-date compared to IRS data). If there is more than a 10 percent difference between the self-attested income and the data source, the state asks for a reasonable explanation from the individual and, if necessary, paper documentation. When the individual attests to income above the applicable standard (100 percent of the Federal Poverty Level [FPL]) and the data source indicates income below the standard, the state accepts attestation and forwards the application to the federal exchange.

See **Table 2** for a description of the attestation decisions and electronic data sources accessed for verification of select eligibility factors discussed during interviews. For some eligibility factors, department staff review information from both the Federal Data Services Hub and other federal and state sources for verification of beneficiary information.

[4] Mandatory managed-care enrollment takes place when AHCA selects a managed care plan on behalf of the beneficiary who can make a change within a certain timeframe if desired; voluntary managed-care enrollment takes place when AHCA alerts the beneficiary how to select a managed care plan if he or she chooses it over fee-for-service.

Table 2. Florida Verification Practices for MAGI Medicaid at Application and Renewal

Select Eligibility Factor	Self-Attestation	Financial and Non-Financial Data Sources			Notes
		Federal Agency	State Agency	Private	
Income	No	Federal Data Services Hub, Work Number data	Department of Economic Opportunity for state wage data, in-state and out-of-state unemployment compensation Department of Management Services (DMS) Florida Retirement Data	Work Number	State wage data more accurate and up to date than IRS data. DMS retirement data is an annual interface so only used at application if current, otherwise at post-enrollment or renewal. Use of Work Number through hub for income verification and to support Public Benefits Integrity (Florida Department of Children and Families [DCF] – DCF's office to prevent public assistance fraud).
Residency	Yes	N/A			If state becomes aware of a discrepancy with information it uses for other verification, reasonable explanation is requested before paper documentation.
Social Security Number	Not allowed	Federal Data Services Hub and Social Security Administration (SSA)			Paper documentation required when inconsistency found in data source.
Citizenship	Not allowed	Federal Data Services Hub and SSA	Department of Motor Vehicles (DMV) and Department of Health Vital Statistics (back-ups)		Paper documentation required when inconsistency found in data source.
Immigration Status	Not allowed	Federal Data Services Hub and Department of Homeland Security (DHS), Systematic Alien Verification for Entitlements (SAVE)			DCF staff have access to DHS's database. Paper documentation required when inconsistency found in data source.
Age	Yes	N/A	Department of Health Vital Statistics (back up)		If state becomes aware of a discrepancy with information it uses for other verification, reasonable explanation is requested before paper.
Medicare	Yes	State Online Query (SOLQ)			If state becomes aware of a discrepancy with information it uses for other verification, reasonable explanation is requested before paper documentation.
Application for Other Benefits	Yes	SSA			DCF staff have access to SSA's database. If state becomes aware of a discrepancy with information it uses for other verification, reasonable explanation is requested before paper documentation.
Incarceration Status		Federal Data Services Hub and SSA data			State used SSA to ensure that no incarcerated individual in a Medicaid household is approved for benefits while incarcerated.

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.

Notes: SAVE is a DHS process for verifying an individual's immigration status either paper-based or electronically. Electronic verification consists of three steps. States can use SAVE Step 1 and, more recently, Step 2 automated functionality through the Federal Hub. Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) data housed in same eligibility system as Medicaid, so no interface is needed. Acronyms are as follows: MAGI – Modified Adjusted Gross Income, N/A – Not Applicable.

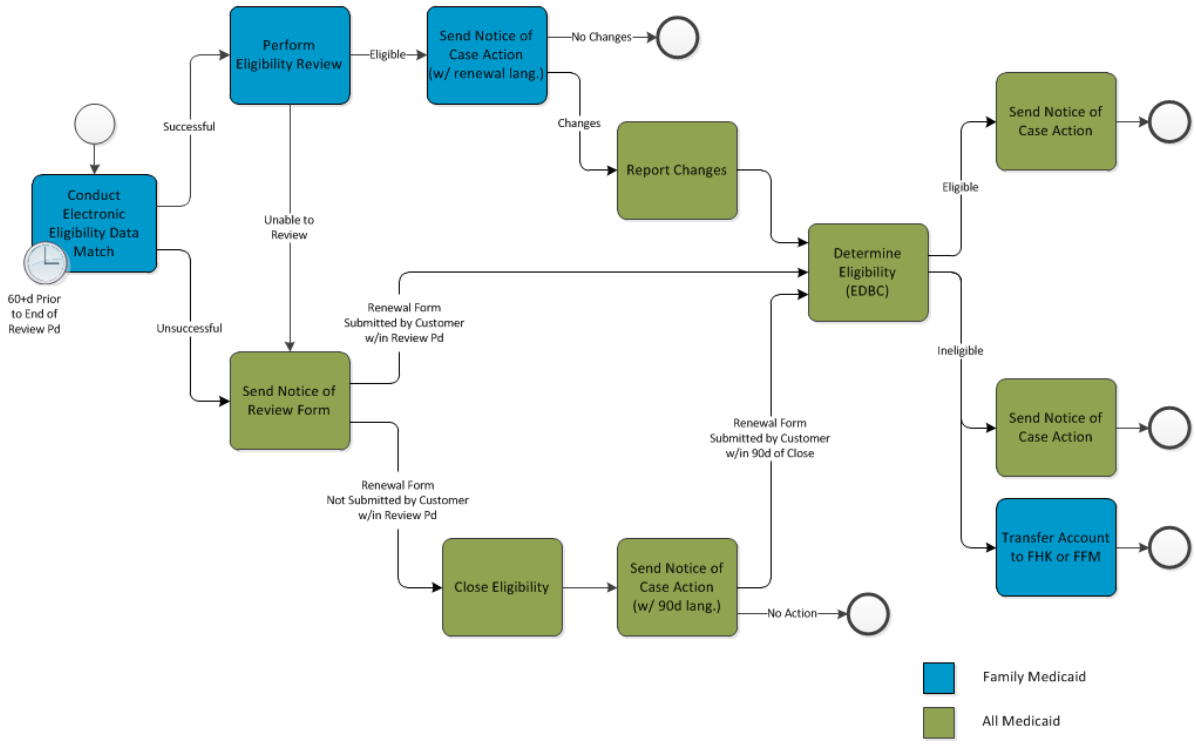
Auto-enrollment and renewal

In Florida, there is a distinction between no-touch and partial-touch eligibility determination for MAGI-eligible individuals, and DCF relies more on partial touch. In response to the ACA, DCF built the infrastructure alongside its legacy system to begin processing no-touch, real-time eligibility determinations for a subset of MAGI Medicaid applicants. DCF set a goal of 20 percent of cases processed in this way, and, according to state respondents, DCF has achieved this target. Respondents indicated that they do as much no touch as they can, suggesting that these cases may most likely be MAGI Medicaid only cases (rather than households eligible for other public assistance programs as well) and that electronic data sources successfully verified income, citizenship, and identity.

More often, DCF processes partial-touch eligibility determinations, meaning cases require worker involvement to review certain factors (income, for example) by checking interfaces with other data sources and imaged documents prior to authorization, meaning Medicaid approvals or denials. "There's some areas where we want the workers to actually look at the screens before they actually authorize the case," said one respondent. According to state data, 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 modernized rules engine for Medicaid and CHIP, as well as electronic data source interfaces and workflow tools, facilitated worker timeliness. In addition, the DCF continuous improvement team, provides technical and policy assistance to field staff and maintains an online review tool to monitor determination accuracy at state and local levels and target areas for improvement. According to state respondents, cases most likely to fail no-touch or partial-touch eligibility determinations include those with no Social Security number on the application or those whose income or immigration status could not be verified using electronic data sources. Once DCF eligibility determinations are made and transferred to the state's MMIS, the Medicaid agency, AHCA, has processes to streamline enrollment into managed care plans.

The ACA also prompted DCF to design a new workflow for Medicaid auto-redetermination in Florida, referred to as auto-renewal. **Exhibit 2** depicts the renewal process for both MAGI and non-MAGI Medicaid programs. Auto-renewal of MAGI Medicaid cases (Family Medicaid shaded boxes in **Exhibit 2**) refers to a low-touch process in which DCF verifies eligibility using electronic data sources. Upon worker review and approval, DCF sends notices to customers that their case is being renewed. According to documentation published just after ACA implementation, the state reported decreases in renewal processing time by three days despite a higher number of monthly renewals and the same number of staff (MAC 2015). During telephone discussions, state staff reported that up to 50 percent of MAGI Medicaid cases are auto-renewed. These estimates are consistent with recent survey data (Brooks et al. 2018).

Exhibit 2. Florida Medicaid Auto-renewal Workflow Post-ACA



Source: Florida Department of Children and Families.

In the event that Medicaid cases cannot be renewed using existing information, agency staff reported requiring customers to re-enter income information at renewal (rather than verify existing data on prepopulated forms). "We were a little hesitant to auto-populate certain things, and that would be mostly the income. Because if the income makes them ineligible…sometimes they don't update the income and they just try to go with it and they continue to be eligible when they may not be. And so…if they go online to the self-service portal, almost all of that information is there for them already.…They can make a change when they're recertifying. Except the income. They need to put that in again."

State staff explained that auto-renewals for combined cases (i.e., customers with both health and non-health assistance) happen differently, specifically citing beneficiaries with both SNAP and Medicaid. Florida extends Medicaid 12 months 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). 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 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. One respondent reported that more frequent income checks are disruptive to beneficiaries. An assister commented that "Every time the family is getting information that's saying, 'Oh, your Medicaid's been reviewed.' Now you're here, you're stressing the families out all over again that their coverage is at risk."

Integration of MAGI Medicaid eligibility determination with other health or human services programs

Florida has long been committed to shared services for public assistance programs. As stated earlier, DCF is the state agency responsible for making eligibility determinations for several health and human services programs as well as maintaining the ACCESS Florida System Architecture. The Florida System, supporting Medicaid, SNAP, and TANF, was in place well before the ACA. According to one state

respondent, “We’re just so used to having an integrated program here (since the early 1990s), so we integrate as much as we can.” Another state respondent identified Florida as one of the first states to launch an online combined application for Medicaid and other human services programs back in 2005. “So from the customer service perspective, it’s better because then they don’t have to provide the financial information over and over and over when they apply for multiple benefits at once.” Florida’s legacy shared eligibility system has not undergone a major overhaul since 2004 (although system updates occur monthly), but Florida’s combined online application, ACCESS, was revised in anticipation of ACA implementation in January of 2014.

State respondents emphasized the importance of strong working relationships between agencies when eligibility determination is separate from the rest of program administration. In recent years, for Medicaid in particular, AHCA and DCF took steps to “institutionalize the relationship.” For example, staff from each agency serve on an eligibility work group and meet monthly to discuss policy and system changes. In addition, AHCA and DCF leadership updated their decades-old interagency agreement and will continue to review it on an annual basis. One respondent commented, “Even if you are in the same agency, if you’re in a large umbrella agency, you need to do those same things. You just need to do them across your internal divisions.…You have to work on it no matter what your [organization] chart says in your state.”

MEDICAID PROGRAM AND BENEFICIARY EXPERIENCES

As described above, Florida’s decision-making as it related to current streamlined enrollment and renewal practices for MAGI Medicaid populations was built around a history of shared eligibility processes and systems for health and non-health programs within DCF, the desire for accurate eligibility determinations, and the use of workers and electronic data sources to verify applicant information. Due to budget and time constraints, Florida maintained its legacy shared eligibility system and built parallel application pathways and rules engines to support real-time determinations for all Medicaid populations. Findings in this section summarize key themes, as identified by key informants, related to Medicaid program and beneficiary experiences, including successes and challenges of the ACCESS combined application pathway, the need for enrollment and renewal assistance, and Medicaid program efforts to streamline managed care enrollment.

Florida’s application pathways for health and non-health public assistance were viewed as good for beneficiaries, but back-end systems are difficult to maintain

Respondents referred to both Florida’s combined and health-only online application pathways as having a positive effect on beneficiaries. Florida DCF has a long history of supporting an online application portal through which individuals can apply for Medicaid, SNAP, and TANF coverage. One state respondent reported: “There’s economies of scale, and there’s one-stop shopping for the recipients to not have to go lots of different places.” The ACCESS combined application pathway was reported to be the most frequently used by beneficiaries.

State respondents also noted that regardless of application pathway, individuals could apply for Medicaid, CHIP, or exchange products. “In Florida we also 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.” However, enrollment assisters reported guiding applicants through the most appropriate application pathway. One respondent pointed out that the ACCESS combined online application pathway can be “onerous” to complete, particularly when an individual is seeking multiple types of public assistance. This respondent also reported, “And I think we have a lot of really high-level enrollment assisters…and so most of us have a pretty good sense of when somebody’s coming in the

door, what is the most direct route to get them through enrollment process. And even though technically there's this no wrong door process, we know it doesn't necessarily work like that for all people. So we usually try to—I think because we have such a breadth of experience, we have at least a pretty good ability to know up front this is the route we ought to be going on with this candidate."

Respondents were candid that while application pathways, systems, and processes are integrated from the customer point of view, back-end systems are fragmented, and some of them are very outdated from the state's point of view. One respondent remarked, "And even like with our staff and our customers, 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."

Assisters reported supporting consumers in several ways, leveraging relationships with agency staff

Each month, tens of thousands of Medicaid cases are processed in Florida without assister involvement; however, enrollment assisters mentioned spending time with consumers to resolve inconsistencies in terms of how the state and local DCF staff and HealthyKids staff apply program rules and policy. One respondent pointed out that income is verified differently for Medicaid and CHIP across DCF and HealthyKids, such that DCF and HealthyKids were "bouncing kids back and forth." This perspective differed from the state's perspective on account transfers between DCF and HealthyKids. One state respondent shared: "[I]f someone applied through the CHIP entity [HealthyKids] and [it] was found that they perhaps were actually eligible for Medicaid, they'd be seamlessly transferred. They don't have to take any action in order for that to be transferred directly to DCF. And vice versa, if DCF finds them not eligible for Medicaid but possibly eligible for CHIP, that goes over to the CHIP entity. So that's all been done to make it seamless to the applicant on the front end." (DCF is responsible for final eligibility determination.) According to data for the first six months of 2018, DCF electronically transferred an average of 11,000 cases per month to HealthyKids and an average of 37,000 cases per month from HealthyKids.

Respondents also noted 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. In terms of verification of immigration status, one respondent reported: "There are a lot of categories of non-citizen who are not illegal, but [they] are not necessarily all consistently being applied."

Assisters also helped consumers interpret DCF notices, such as denial notices or notices of case action (which require additional information from beneficiaries). One respondent described notices in this way: "What I'm finding, 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." The same respondent went on to say: "I think most consumers, when they get the news that they're ineligible for services, whatever it is, under whatever program, they don't hear what follows, they just hear you're ineligible for this. So they don't hear you may still be eligible for whatever else. So that makes it really difficult for consumers because they don't typically take the next step to find these other programs and these other services." State respondents highlighted improvements over the last ten years with simplifying and clarifying notices but this work was ongoing (see the Looking Forward section of this report).

Two respondents representing different types of enrollment assisters spoke to the importance of having relationships with senior staff in each of the agency offices in order to overcome barriers to coverage. They referred to the ability to "pick up the phone" and call contacts in other programs to troubleshoot stalled applications or inaccurate eligibility determinations. "On the positive side…I hear my assisters making comments about them having good relationships with their [agency] counterparts."

Respondents cited ACCESS online application features as a time saver for beneficiaries and individuals assisting them

DCF designed the ACCESS Florida application portal to offer customers direct access to public assistance any time of the day, any day of the week. According to one state respondent, "[W]e do a lot to enable our customers to be self-sufficient. We have had our self-service portal for years now and the MyACCESS account for the customers." While not a new innovation in the state, the self-service portal and its document management and imaging system were described by respondents as efficient for beneficiaries and workers. One state respondent shared: "[W]hen we are talking about the self-service portal, this includes an account where individuals can not only apply for benefits or submit a renewal for benefits, but also they can check the status of the application. If they are owing or they should provide any kind of verifications requested by the department in order to determine eligibility, they can also upload documents required for eligibility determination, all those processes." Another respondent spoke to the document system specifically as a facilitator of streamlined Medicaid eligibility determination and re-determination. "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 can upload documents to their MyACCESS accounts, and workers can access images of these documents for verification purposes.

Enrollment assisters shared that the MyACCESS account facilitates their work. For example, one respondent preferred that account set-up takes place at the same time as application submission, as a one-step process, with MyACCESS. The HealthyKids application pathway, on the other hand, does not incorporate account set up until after application submission, a two-step process. While assisters must access the account with a beneficiary, respondents also reported efficiencies from having all applicant information in one place, including notices and verification documentation. "I can see what letters went out, the different steps of determination, and all of that. Well, it's a time saver. It is also for the consumer; it helps us do a better job at providing assistance because we have more on-time, very timely, real-time accurate information about what's going on."

Recent Medicaid agency efforts expedited enrollment of beneficiaries into managed care

Medicaid agency staff described two innovations in the last three years that accelerated beneficiary access to managed care services. First, AHCA implemented an interactive voice response (IVR) enrollment portal where customers can log in at any time during the eligibility determination process to select a managed care plan. This portal is completely separate from the MyACCESS account. Prior to the online IVR enrollment portal, customers used call centers, which primarily operate on weekdays. According to a state respondent, "We were surprised [at] how popular it was. And of course that shifts a huge load off of call centers as well, and so I think everybody wins on that. [It] saves our Choice Counselors for people who really do need to work through things or talk to someone about it as opposed to the majority of people who just want to get it done. They can read the information online and make their choice and they're totally fine with that." This innovation was reported as beneficial for both MAGI- and non-MAGI customers, particularly in terms of allowing caretakers to make choices on behalf of beneficiaries.

In January 2016, AHCA implemented a process in which a subset of beneficiaries are automatically enrolled into a managed care plan once eligibility is determined (referred to earlier in this report as mandatory managed-care enrollment), thus reducing unnecessary transitions from fee-for-service Medicaid to managed care. This population can choose a different plan within a certain timeframe, if desired. State respondents reported, "We feel very strongly that our managed care product is far superior to our fee-for-service system, and so we want to get people into our managed care system as soon as possible. And so we didn't want people to spend anywhere from two to six weeks floundering around in the fee-for-service system when they could be having all these other great benefits." State respondents referred anecdotally to high percentages of beneficiaries remaining in the managed care plans to which they were auto-assigned as evidence for the success of this policy.

LOOKING FORWARD

As interview respondents reflected on Florida's MAGI Medicaid enrollment and renewal practices, they identified some issues under evaluation, including process and system changes.

Efforts at DCF to improve ACCESS online combined application

Respondents reported that work is underway to enhance the usability of ACCESS for customers. Specifically, the state is exploring mobile-friendly features that would make it easier for customers to submit applications and update information via a smartphone or tablet. One respondent stated, "Just because we have an online application…it's not always compatible with a phone or a tablet, so we would really like to be able to use something that people can, if they need to take a picture and upload their document to apply or recertify, report changes, they can do all that from their phone or from a tablet." The state reported ongoing interest in modernizing its decade-old document management platform. Another respondent said, "The imaging recognition technology available nowadays is pretty advanced. We would love to be able to create something like that in this state in social services."

Hope to enhance the modernized rules engine to support non-health programs as well

Maintaining the legacy shared eligibility system requires a considerable investment of time and resources, and respondents report that the budget does not support their wish list for system enhancements. Changes prompted by policy or information technology upgrades in an old legacy system are expensive. One respondent explained, "It's just not programmed in such a way that you can easily change one thing without breaking everything else." System enhancements to support state innovations to streamline enrollment are also costly. For example, one respondent reflected on a recent enhancement, explaining that "It drained—it made them push back major priorities." This respondent went on to say that "it's just really, really difficult…to be the kind of cutting-edge agency…with a shoestring budget."

State agency staff are continuing efforts to obtain funding to house rules engines for health and non-health programs under one modernized platform. One respondent said, "We would like to have [the non-health programs] all in our rules engine, but we have not been able to do that yet. So far, right now our rules engine has all of our Medicaid in there including the family related and adult related, but not our food assistance or cash."

Hope to establish a new, more robust notice platform

State respondents reported being well aware that notices sent to beneficiaries generate confusion. They emphasized the need to establish a new, more robust notice platform (i.e., the system that generates the notices) when resources become available. Respondents pointed out that 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 considered to be not sufficiently explicit in terms of an explanation) and take into consideration notice readability.

Florida Medicaid transition to a modular platform for key systems in accordance with CMS guidelines

AHCA is embarking on a major modernization effort to transition its MMIS and other key systems to a Medicaid Enterprise System (MES) platform. While not directly affecting eligibility, enrollment, and renewal at this time, AHCA anticipates that future phases of this transformation to modularity and interoperability will include changes to further streamline enrollment and renewal for customers. Solutions may include improved information exchange across agencies and data aggregation. According to one state respondent, “I think there will be opportunities for us to work more with the recipients and figure out what they're looking for and how to make it easier for them to interact with us. DCF will be part of all of this, especially when it gets to the recipient side of things to try and say, how do we make it seamless for the recipients?”

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APPENDIX

PRE-TELEPHONE DISCUSSION DATA COLLECTION FORM

MACPAC ELIGIBILITY, ENROLLMENT, & RENEWAL PROCESSES AND SYSTEMS STUDY

PRE-TELEPHONE DISCUSSION DATA COLLECTION FORM: FLORIDA

We realize that your agency is extremely busy. In order to maximize our time together on the telephone, we are requesting that you review this form to verify blue text or enter in the blue shaded areas information about your current Medicaid program and supporting eligibility systems. Please make any corrections directly on/in the document. This form should take about 10 minutes to complete.

1) **Name of Medicaid Agency:** Agency for Health Care Administration

2) **What is the PRIMARY agency responsible for Medicaid eligibility determination at ENROLLMENT if different from Medicaid agency above:**
Department of Children and Families

3) **What is the PRIMARY agency responsible for Medicaid eligibility determination at RENEWAL (if different from #3):**
Department of Children and Families

4) **Please confirm other governmental or quasi-governmental agencies/organizations/programs that regularly work with the PRIMARY agency above on Medicaid eligibility determination:**

Agency Name	Agency Type	Involved at Enrollment (Check if yes)	Involved at Renewal (Check if yes)
	Separate CHIP	☒	☐
	Other State Agencies	☐	☐
N/A	State-based Marketplace	☐	☐
Healthcare.gov	Federally Facilitated Marketplace	☒	☐
Enter specific areas if not statewide:	County or City Agencies	☐	☐
Enter name:	Other	☐	☐

5) **Please identify and describe the primary computer or information technology (IT) system currently used by agency staff to support individual Medicaid eligibility determination, re-determination, and/or tracking for Florida's MAGI Medicaid populations.**

System Name: Automated Community Connection to Economic Self Sufficiency (ACCESS)
Year System Implemented: 2004
If not replaced in the last 10 years: Major System Modification? **Yes x No ☐ N/A ☐**
Year of Major System Modification: 2013/2014
Vendor(s) Used for Recent System Replacement/Major Modification: Deloitte
System Statewide: **Yes ☒ No ☐**
If no, please describe geography covered: ---

6) Please identify the other programs/benefits for which individual eligibility is determined and/or tracked through the primary Medicaid eligibility system named in Question #6 above.

Name of Program/Benefit	Type of Program/Benefit	Integrated at Application (Check if yes)	Integrated at Renewal (Check if yes)
KidCare	CHIP	☒	☒
Medical Assistance	Other Non-MAGI Medicaid programs	☒	☒
	Other non-Medicaid health insurance programs (Marketplace, commercial plans, etc.)	☐	☐
	SNAP	☒	☒
	TANF	☒	☒
	Child care	☐	☐
	Child support	☐	☐
Enter name:	Other non-health programs/benefits	☐	☐

7) Please provide an estimate (in Column A) of the timeliness of MAGI Medicaid eligibility determination at application and the extent to which renewal is automated in Florida. Alternatively, please verify the survey data (in Column B) from the source cited below.

	A. Percent of Applications (estimate)	B. Percent of Applications (Kaiser/Georgetown Survey)*
MAGI eligibility determinations are completed within **24 hours** of application	**25-45**	**25-50**
MAGI eligibility determinations are completed within **one week** of application	**45-65**	
MAGI cases are **auto-renewed** (also known as ex parte renewal, passive renewal, or administrative renewal)	**25-50**	**25-50**

*Source: Brooks, T., Wagnerman, K., Artiga, S., and Cornachione, E. 2018. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2018: Findings from a 50-State Survey. Washington, DC: Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured. http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018.

8) Please confirm that the Medicaid/CHIP Eligibility Verification Plan for Florida on record with CMS is up to date. The information we have for Florida is found here:

https://www.medicaid.gov/medicaid/program-information/eligibility-verification-policies/downloads/florida-verification-plan-template-final.pdf

Is this the most current verification plan? **Yes** ☐ **No** ☐

If not, where can we access the current verification plan? *Please provide link or attach with date.* Verified in discussions with state contact

9) Please indicate which IT resources are used to support eligibility determination and renewal for Florida's MAGI Medicaid populations.

Information Technology Resources	Start Year	MAGI Medicaid only? (Check if yes)	Is this resource used at application (Check if yes)	Is this resource used at renewal (Check if yes)
Multi-benefit/combined online application for health insurance programs	2005	☐	☒	☒
Multi-benefit/combined online application for health and non-health insurance (e.g., food stamps) programs	2005	☐	☒	☒
Online eligibility screening tools	2008	☐	☒	☒
Self-service case management for clients, e.g., to check application status, report changes, renew	2008	☐	☒	☒
Document management or imaging tools for clients, e.g., to support upload and routing	2008	☐	☒	☒
Mobile applications for clients		☐	☐	☐
Document management or imaging tools for staff	2006	☐	☒	☒
Staff portals	2007	☐	☒	☒
Navigator/assister portals		☐	☐	☐
Business rules engines to automate calculations based on rules and logic	2014	☐	☒	☒
Eligibility system interface with MMIS, e.g., claims	2008	☐	☒	☒
Other IT resources, e.g., applications/tools, online accounts or portals, system modifications or interfaces				
Specify other IT resource:		☐	☐	☐
Specify other IT resource:		☐	☐	☐

10) Of the IT resources listed above, which would you describe as most critical to supporting MAGI Medicaid eligibility determination and renewal? Rank the top three.

#1	Multi-benefit/combined online application for health and non-health insurance (e.g., food stamps) programs
#2	Business rules engines to automate calculations based on rules and logic
#3	Document management or imaging tools for clients, e.g., to support upload and routing

Thank you for your time!