Coordinating Human Services Programs with Health Reform Implementation

A Toolkit for State Agencies

The Center on Budget and Policy Priorities, located in Washington, D.C., is a non-profit research and policy institute that conducts research and analysis of government policies and the programs and public policy issues that affect low and middle-income households. The Center is supported by foundations and individual contributors.

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Executive Summary

By making affordable health care available to millions of low-income, uninsured Americans, the Affordable Care Act (ACA) will go a long way towards helping families who struggle on a daily basis to afford life's most basic necessities. Health care reform's impact on low-income people's lives, however, goes beyond providing them health insurance coverage. It has the potential to significantly affect low-income individuals and families' ability to apply for and receive other benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and child care subsidies, that are critical to helping them make ends meet.

When the ACA's coverage expansions take effect, it is likely that a large share of people (mostly parents and adults without children) who will be newly eligible for Medicaid coverage will already be enrolled in SNAP or other benefit programs. In other cases, individuals who apply for health coverage due to the new law will not have had contact with state human services in the past and many may be eligible for other benefits, such as SNAP, child care subsidies, or energy assistance. Careful consideration of how states will address and leverage applicants' or participants' connection to other benefits and services as a part of their health reform implementation efforts could help to yield better outcomes for families and efficiencies for state administration.

Why Use the Toolkit?

As states approach the question of how to implement the ACA's coverage expansion, they face numerous questions about how to structure their processes and workforce, and how to use technology and other resources within federal rules. Careful consideration of these issues now could facilitate better outcomes for families. And, it could reduce inefficiencies for states by eliminating unnecessary redundancies in state administration and operation of these programs.

States will need to tackle these key questions:

- How will people who apply for human services programs be informed about and given the opportunity to apply for Medicaid? In most states, families who apply for benefits at a local human services office are routinely screened for and, if eligible, enrolled in health coverage. Will that still be the norm in 2014? Or will the poorest families face added burdens to accessing health coverage because they can only seek health benefits through some other process?

- How will low-income people who apply for health coverage through the state's online application be connected to other human services programs and benefits? When low-income individuals apply for health coverage and qualify for Medicaid, will there be a process to help connect them to other benefits and services for which they might be eligible?

Put another way, will it be harder or easier in 2014 for the poorest families to access (or for states to deliver) the package of services for which they will be eligible, including health coverage?

State choices with respect to these issues will have an enormous impact on poor families' and individuals' access to key benefits and services. This toolkit is designed to help states sort through those choices. Specifically, it is intended to guide states in developing an eligibility system and process that meets the standards and requirements of the ACA, with a particular focus on ensuring that poor or near-poor families have a way to access the full package of available benefits. It raises issues and questions that states need to consider

to ensure that these families' experience with obtaining benefits is not only protected, but improved, as states modify and upgrade their systems.

What Does the Toolkit Cover?

Each module of this toolkit provides states with tools and suggestions for a guided process that can be used to review the current eligibility and enrollment service delivery model and compare the current model to the desired future model. The modules provide context on the importance of the topic being addressed and how a state's decision on the issue can affect a family's ability to access multiple benefits.

The toolkit covers the following topics:

- **Eligibility Process.** This module will help states identify decisions about how their eligibility processes and structures will operate in 2014 and beyond. It is intended to facilitate discussion about how decisions related to the ACA will affect overall service delivery of benefits in a state.
- **Applications.** This module will help states take stock of how well their current applications perform in order to identify additional improvements that should be incorporated in the design of a new, ACA-compliant application. It will also help states identify questions that would need to be added to a Medicaid application to make it a multi-benefit application that can also be used for SNAP and other human services programs.
- **Verifications.** This module helps states identify opportunities for streamlining verification policies and processes across programs. It starts with a review of states' current verification practices and walks through issues that states should consider in designing a verification process that minimizes the burden on families.
- **Renewals.** This module provides a framework for a guided process that state agencies can use to review how they currently conduct renewals, and design a new process to meet the ACA requirements.
- **Staff Readiness.** This module will help states assess their current staffing model, including taking an inventory of their current position descriptions, organizational structure, performance management system and staff training.
- **Project Management and Communications.** This module provides states with tools to kickoff their planning for ACA implementation. It walks through how to create an outline of a project plan, define team members' roles and responsibilities, develop a project calendar, and create an outline of a communication plan.

Each module also contains instructions on how to complete the section, including what materials and resources are needed, suggestions for information or data that should be gathered in advance, as well as estimates of the amount of time and effort that states might consider devoting to the process. While the topics covered in each of the sections are interrelated, each section is designed to stand on its own, so that states can complete only certain sections if they so choose.

Introduction

Why It Is Critical to Address Program Integration Issues in Health Care Reform

By making affordable health care available to millions of low-income, uninsured Americans, the Affordable Care Act (ACA) will go a long way towards helping families who struggle on a daily basis to afford life's most basic necessities. Health care reform's impact on low-income people's lives, however, goes beyond providing them health insurance coverage. It has the potential to significantly affect low-income individuals and families' ability to apply for and receive other benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and child care subsidies, that are critical to helping them make ends meet.

When the ACA's coverage expansions take effect, it is likely that a large share of people (mostly parents and adults without children) who will be newly eligible for Medicaid coverage will already be enrolled in SNAP or other benefit programs.[1] In other cases, individuals who apply for health coverage due to the new law will not have had contact with state human services in the past and many may be eligible for other benefits, such as SNAP, child care subsidies, or energy assistance. Considering how to address and leverage applicants' or participants' connection to other benefits and services is important for several reasons.

Integrated Processes Avoid Duplication and Help States Respond Cost-Effectively to Elevated Need

Maintaining or building duplicative processes for programs with similar eligibility rules is inefficient and costly. Integrating processes across multiple benefit programs can help states manage their resources, which will face increased demands under the ACA. States are already struggling with the significant increase in program caseloads brought on by the most recent recession. While the state of the economy is improving, it will take several years for unemployment levels to drop, and the demand for state services and supports related to programs such as Medicaid and SNAP is unlikely to relent anytime soon.

States also will face a significant challenge in processing applications for large numbers of individuals in 2014 and future years. The requirement that people have health insurance, along with outreach that will publicize the health reform's coverage expansions, will bring millions of newly eligible people into Medicaid, as well as people who are eligible now but not enrolled. What's more, as people who have not had contact with state human services in the past learn about other state administered benefits, such as SNAP and child care subsidies, when they apply for health care coverage, applications for those programs may also increase.

At the same time that caseloads are increasing, states continue to face large budget gaps and are struggling to find the revenue needed to support critical public programs. Thirty states have projected (and in some cases have already closed) budget gaps totaling $49 billion for fiscal year 2013.[2] Unfortunately, states' options for addressing these shortfalls are more limited and involve tougher trade-offs than in past years.

Given the combined pressures of limited budgets and increasing caseloads, states have little choice but to eliminate systemic redundancies and develop more efficient processes so they can do more with fewer resources.

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[1] CBPP estimates that approximately one-fourth of SNAP participants will gain Medicaid eligibility under the ACA. In some states this share is as high as 47 percent.

[2] Elizabeth McNichol, Phil Oliff and Nicholas Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, updated March 2012.

Integration with Human Services Is a Cost-Effective Way to Enroll New Medicaid Eligibles

Integration with human services programs will be an important strategy to reach individuals newly eligible for health coverage in 2014. As mentioned previously, many of the people who will be newly eligible for Medicaid are already in contact with state human services. Federal SNAP income eligibility is 130 percent of the poverty line, which means that most SNAP households have at least one member — often a child — who is eligible for Medicaid now.

The overlap in SNAP and Medicaid eligibility will be even greater in 2014, when Medicaid extends coverage to parents and childless adults with incomes up to 133 percent of poverty. In fact, many low-income parents and adults without children who will gain Medicaid eligibility in 2014 are currently eligible for and receiving SNAP benefits. A Center on Budget and Policy Priorities analysis found that about 6 million adult SNAP participants will likely become newly eligible for Medicaid under the health reform law. This amounts to about one-third of the expected increase in Medicaid enrollment as a result of health reform. In more than half the states, more than 50 percent of current SNAP households contain a member who will be newly eligible for Medicaid in 2014 (see Figure 1). In addition, an estimated 95 percent of non-elderly individuals who are on SNAP will be eligible for Medicaid (including individuals who will be newly eligible as well as those who are currently eligible but not enrolled in Medicaid).[3]

Because the state already knows who is receiving SNAP, streamlining enrollment policies and practice so people on SNAP can be automatically (or more expeditiously) enrolled in Medicaid in 2014 will be an important strategy for responding to the pending enrollment surge and ongoing workload. SNAP has a very high participation rate among those eligible for the program — over 80 percent among families with children and over 60 percent among non-elderly, childless adults — so using SNAP participation as a way to connect eligible parents and other adults to Medicaid will be an important outreach tool.

Moreover, states already spend considerable effort rigorously evaluating income for SNAP participants at least every six months, and participants are required to report changes in income that would make them ineligible (known as threshold reporting) so this information should be considered timely and accurate. It would be good practice for states to make SNAP information available to the Medicaid program.

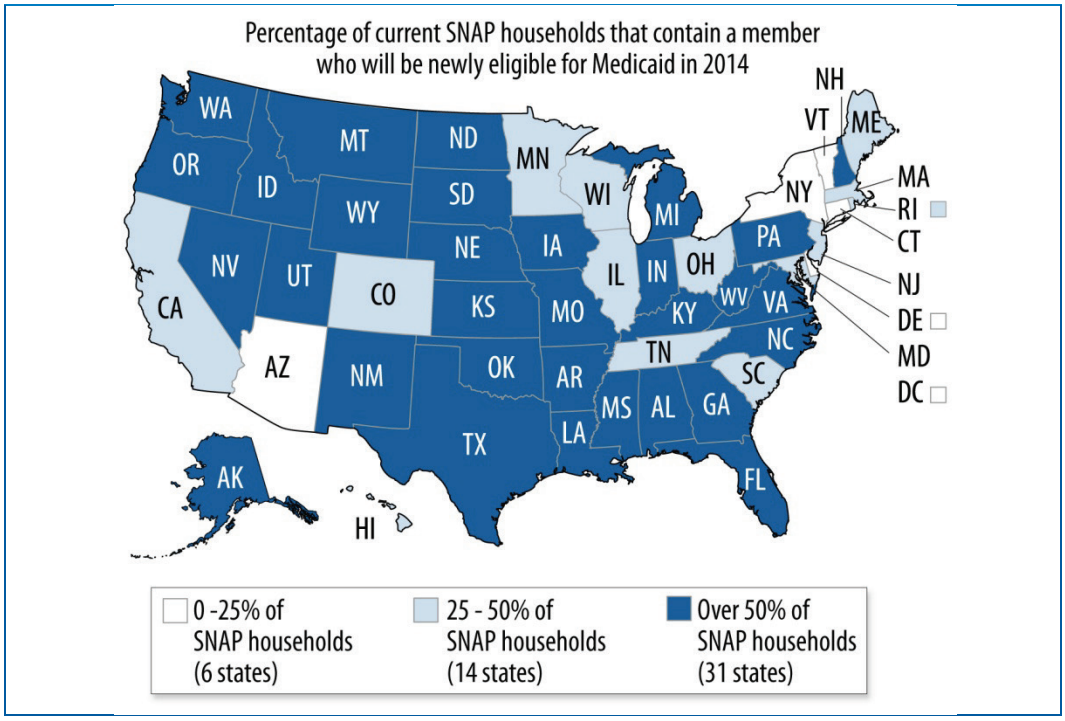
Integrating Technology Up Front Is Cost-Effective for Both Human Services and Medicaid, Especially with High Federal Match

When developing new systems, it is always most cost-effective and efficient to build in cross-program coordination capacity from the start, rather than retrofitting the technology later. In addition, the federal government is providing financing for Medicaid systems development, making it even more economical for states to integrate technology up front.

The vision for health reform is that it will use modern business techniques — that people interested in coverage will apply online, and much of the process for documenting their eligibility will occur in real time, based on electronic data matches. To help achieve this vision, U.S. Department of Health and Human Services (HHS) will provide states with an enhanced federal Medicaid match (90 percent) to support the design, development, testing, and implementation of new or enhanced eligibility systems.

[3] Center on Budget and Policy Priorities analysis of SNAP Quality Control data for fiscal year 2010.

Figure 1. In Most States, Over 50% of Current SNAP Households Will Include a Member Who Will Be Newly Eligible for Medicaid



Source: Center on Budget and Policy Priorities analysis of SNAP Quality Control Data for fiscal year 2010.

In addition, joint guidance issued by HHS and the U.S. Department of Agriculture (USDA) says that states need not allocate the costs involved in developing the information systems to support eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP), regardless of whether other programs benefit. The state must charge only the incremental costs for additional requirements to integrate non-health programs to those specific programs, at the lower match rate provided by those programs. States will benefit from the 90 percent match and temporary waiver of cost-allocation rules through December 31, 2015. HHS also will provide an ongoing 75 percent match once such systems are operational.

Thus, states can design and build the basic technological infrastructure (e.g., hardware, rules engines, client correspondence mechanisms, interfaces with other systems) of an integrated system for Medicaid and receive the 90 percent match, and then supplement it with additional "modules" for other programs (and get reimbursed separately by those programs). Because states already have to upgrade and redesign their Medicaid eligibility systems, this is an excellent time to consider integrating other programs and their corresponding enrollment systems.

The ACA Requires IT Systems that Facilitate Integration

The ACA envisions that states will connect individuals applying for health coverage to other human services benefits. It requires states to seamlessly connect individuals eligible for health coverage in Medicaid, CHIP, or the exchange to the right program, regardless of where they apply.

For example, Section 1561 of the ACA requires HHS to establish standards for how new information technology systems will support applications to the health care exchanges that also connect families to other human services benefits. State Medicaid systems must meet these standards to qualify for the 90 percent

federal match. In addition, the Medicaid eligibility rules require states to use data from other human services programs — and specifically SNAP — to verify information provided by applicants to establish Medicaid eligibility.

These requirements for developing interoperable systems and sharing data across programs will be critical to helping families apply for and keep benefits. SNAP income data are no more than six months old, and because the program's verification and reporting rules are strong — states are subject to rigorous SNAP quality control review and associated penalties for low accuracy — the data are reliable. Thus, by tapping into the their SNAP databases, states can ease some of the burden — on both clients and caseworkers — involved in documenting and verifying income information for Medicaid eligibility. Using this process, states should be able to dispatch these cases more quickly, enabling them to focus more on Medicaid applicants who are new to the system.

Without Integration, Low-Income People Could Actually Lose Medicaid Coverage

Past experience has shown that major eligibility system changes can lead to families losing benefits. In the late 1990s, after the implementation of welfare reform, Medicaid enrollment declined substantially. While part of the enrollment declines could be attributed to a strong economy, difficulties with the administration of benefits also played a key role. For example, in some eligibility systems, Medicaid and Temporary Assistance for Needy Families (TANF) eligibility were not considered independently so that Medicaid benefits were inappropriately terminated when a family left welfare. In other cases, families did not have a way to apply only for Medicaid benefits without having to fill out a combined Medicaid and TANF application.

Major systems changes bring major risks to poor families, and ACA implementation is no different. With the health community's new focus on ensuring seamlessness across insurance affordability programs (Medicaid, CHIP, and premium tax credits), states should not lose sight of the importance of coordinating with human services programs as well.

In particular, in states that co-administer Medicaid eligibility with eligibility for other human services programs, splitting off these functions poses a serious risk (at least in the short term) that individuals and families will lose coverage. In these states, many low-income people are accustomed to going to a single place — the local welfare office — to apply for multiple benefits. Despite efforts to provide new ways for people to apply for and renew benefits, such as online or by phone, a core group of people will continue to seek benefits in person through the local welfare office.

If states change their processes so that individuals can no longer apply for Medicaid through those offices, or they create an additional step to obtaining coverage outside of a household's regular SNAP or children's health insurance renewal process, these individuals may not apply for Medicaid at all, or they may wait until they experience illness before seeking it out. Maintaining a solid connection between human services and Medicaid is a sensible approach for the lowest-income people and ensures that those who apply for benefits through the human services door also have a path to Medicaid.

A Complete Package of Supports is Most Beneficial for Struggling Individuals and Families

Perhaps the most important reason for engaging in cross-program integration is that providing the poorest individuals and families access to the full package of benefits for which they are eligible is critical to helping them make ends meet and stabilizing their circumstances. Too often, poor families with little to no disposable income are faced with very difficult choices, such as delaying payment on the utilities to seek health care for a child, or going into debt to pay rent or put food on the table. Programs such as Medicaid, SNAP, child care subsidies, housing assistance, and others are important to supporting these families and putting them on a path to self-sufficiency.

Helping families overcome poverty and become more self-sufficient requires a coordinated approach to delivering benefits. Research has shown the positive impact that each of these programs have on families. SNAP protects poor families from hardship and hunger. Parents who receive child care benefits are better able to pay their bills on time and provide for their children. Children on Medicaid and CHIP have better health and educational outcomes.[4] Receipt of just one of these benefits makes a significant difference to a low-income family. But lifting most families out of poverty requires providing them with the full range of supports that are available. Providing a family with health coverage but failing to connect them to other benefits like SNAP and child care is a missed opportunity to give these families the supports they need.

The Big Picture: Health Reform's Implications for Program Integration

The ACA will dramatically increase the number of people with access to affordable health care starting in 2014. Currently, Medicaid covers many low-income individuals but leaves significant segments of people out. It generally does not cover adults without dependent children, and only covers parents at very low income levels. Medicaid eligibility also varies significantly from state to state. For example, some states cover children up to 400 percent of the poverty line, while other states have lower income eligibility thresholds. In a handful of states, parents cannot qualify for Medicaid if they earn more than 24 percent of the poverty line (or $5,763 per year for a family of four). Figure 2 shows at what income levels people can be eligible for Medicaid in the median state.

Under the ACA, Medicaid eligibility will be expanded to cover most non-elderly, non-disabled individuals with incomes up to 133 percent of the federal poverty line (FPL), or about $30,700 for a family of four.[5] This expansion of Medicaid, which sets a national minimum standard for Medicaid eligibility, is a significant improvement in coverage over current law and is the foundation of coverage initiatives in the ACA designed to ensure that all Americans have a pathway to health coverage.

In addition to the Medicaid expansion, those with incomes too high to qualify for Medicaid but earning less than 400 percent FPL will be eligible to receive premium tax credits to help defray the costs of purchasing coverage through the newly established exchanges. The Congressional Budget Office estimates that by 2022, eight years after the coverage provisions go into effect, 33 million Americans who otherwise would be uninsured will gain coverage. About half of these, or 17 million people, will newly enroll in state Medicaid programs.[6]

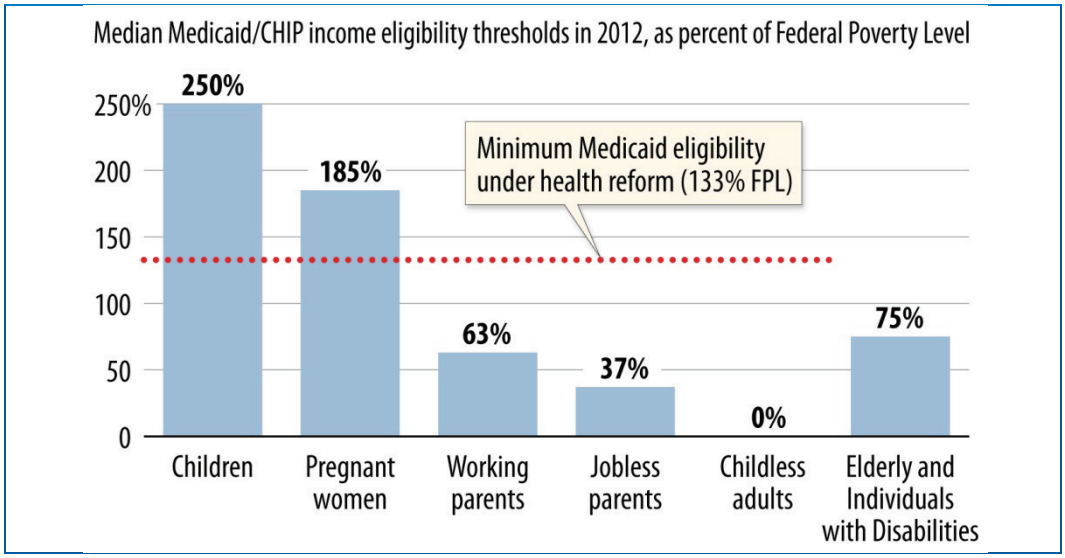
The health reform law will bring enormous changes to states in 2014. There will be a huge influx of new people interacting with the Medicaid program, as well as many new rules for determining Medicaid eligibility. These new rules emphasize a "no wrong door" system for eligibility that connects eligible individuals to the right health coverage program regardless of where they apply, and harnesses technology to minimize or eliminate unnecessary paperwork. As a result, states will have to change their application forms and procedures (including forms and processes that encompass other programs), significantly upgrade their eligibility systems, develop

[4] Research on the effects of these programs is summarized in Gregory Mills, Jessica F. Compton, and Olivia Golden, "Assessing the Evidence about Work Support Benefits and Low-Income Families," February 2011, The Urban Institute.

[5] The ACA does not increase the income eligibility threshold for the elderly and disabled individuals. In addition, legal immigrants who do not meet the five-year residency requirement will not be eligible for Medicaid but will be eligible to receive premium tax credits. The federal government will assume 100 percent of the Medicaid costs of covering newly eligible individuals for the first three years that the expansion is in effect (2014-2016). Federal support will then phase down slightly over the following several years, and by 2020 (and for all subsequent years), the federal government will pay 90 percent of the costs of covering these individuals.

[6] Congressional Budget Office, "Medicaid March 2012 Baseline," March 13, 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf.

Figure 2. Most People with Incomes Up to 133% of the FPL Will Qualify for Medicaid in 2014



Source: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

methods for rapidly accessing data and verifying information provided by applicants, and rethink how they conduct business to fit health reform's vision of a simple, streamlined eligibility and application process.

How states respond to these required changes will be influenced by where they fall in the health care coverage spectrum, the needs of the clients they serve, what policies and processes they currently have in place, the resources that are available, and their programmatic priorities. But regardless of how a state chooses to address the ACA requirement, what is clear is that the changes that states will need to make to their Medicaid programs will necessarily have a significant impact on the administration of other human services programs as well.

Recognizing that most families who are eligible for Medicaid may also be eligible for other human services programs and vice versa, many states have embarked on efforts to make it easier for families to access such services. For example, today, more than 40 states have integrated Medicaid and Supplemental Nutrition Assistance Program (SNAP) processes for families that apply through the welfare office, and almost all states have an application that can be used to apply for multiple types of benefits.[7] As states move forward with health reform implementation, it is important to maintain these linkages and to make sure that low-income families do not face more barriers to accessing the programs and services that they need. States will need to tackle these key questions:

- How will people who apply for human services programs be informed about and connected to Medicaid? As noted, in most states, families that apply for benefits at a local human services office are routinely screened for and, if eligible, enrolled in health coverage. Will that still be the norm in 2014? Or will the poorest families face added burdens to accessing health coverage because they can only seek health benefits through some other process?

[7] U.S. Department of Agriculture, "Supplemental Nutrition Assistance program: State Options Report," November 2010, http://www.fns.usda.gov/snap/rules/Memo/Support/State_Options/9-State_Options.pdf.

- How will low-income people who apply for health coverage through the state's online application be connected to other human services programs and benefits? When low-income individuals apply for health coverage and qualify for Medicaid, will there be a process to help connect them to other benefits and services for which they might be eligible?

Put another way, will it be harder or easier in 2014 for the poorest families to access the package of services for which they will be eligible, including health coverage?

State choices with respect to these issues will have an enormous impact on poor families' and individuals' access to key benefits and services. To be sure, health reform implementation alone presents an enormous challenge for states. Because of the tight timeline for changing Medicaid eligibility processes and setting up the exchanges, some states might be tempted to wait until the law is fully implemented before addressing these cross-program integration issues, but this could lead to missed opportunities and make it harder to take these issues into account down the road.

A Different Kind of Different

Medicaid eligibility was set up under health reform to align with the subsidies available to purchase exchange coverage which will be administered through the tax code. As a result, many of the new rules in both programs originate in the tax code rather than traditional benefit programs. These differences can make coordination more difficult, but not impossible. It's important to remember that Medicaid, SNAP and other human services programs have long had some key differences, particularly with respect to household composition and some income counting rules. Despite their individual rules, many states have had tremendous success in co-administering and coordinating these programs. The new differences need to be understood and addressed. Although they may be frustrating, they are not insurmountable.

State Choices for Implementing Health Reform and Integrating Programs

States face myriad choices in designing their enrollment pathways: should they offer applicants the ability to apply simultaneously for multiple programs? How do they ensure paper documents from clients get to the right caseworkers in time to support a decision? What is the best way to answer families' questions about their benefits? The manner in which states accomplish all of the individual tasks — as well as how they weave their various systems together — defines their business delivery model. Individual states take a variety of approaches, and no design is right or wrong. In the end, the effectiveness of a state's model will determine whether a state fully supports program integration or may be inadvertently undermining it.

Ideally, an integrated process that best uses the opportunities provided in the ACA would recreate a process that is seamless and holistic from the family's perspective, and would use new technologies and deploy human resources as efficiently as possible. But realistically, it is difficult to start from scratch and completely revamp a system for delivering benefits that has been in place and is used by caseworkers throughout the state for decades. Even if a state decides that a wholesale change is necessary and feasible, careful thought and planning needs to go into how to transition to a new model.

Thus, the challenge for states will be to fit the pieces together in a way that builds on the strengths of their current structures while maximizing the possibilities for new investments and improvements. In some cases a state may need to make incremental changes — finding short-term solutions at the same time it makes longer-term improvements.

The key to developing more effective and efficient application, enrollment, and renewal processes is to shine a bright light on what's currently in place, find the duplications and the bottlenecks, strip away policies and procedures that are neither required by federal law nor adding value, and then continually reassess the results and make refinements. Creating "process maps" of a state's eligibility systems can be a very useful first step. These maps can be helpful for visualizing how a new process might work, where problems might occur and what the process will look like from both the family and the state staff perspectives. They also can be helpful in fostering dialogue within the state about which features of the current process are working and worth keeping and the greatest opportunities for change and improvement.

This endeavor requires openness to the possibility that many aspects of the state's current process reflect state choices rather than federal rules, as well as the flexibility to re-imagine how the work could be done differently. And, because states' processes may have redundant steps across programs, these efforts can illuminate opportunities for improved efficiencies through coordination.

Potential Models for Coordinating Service Delivery

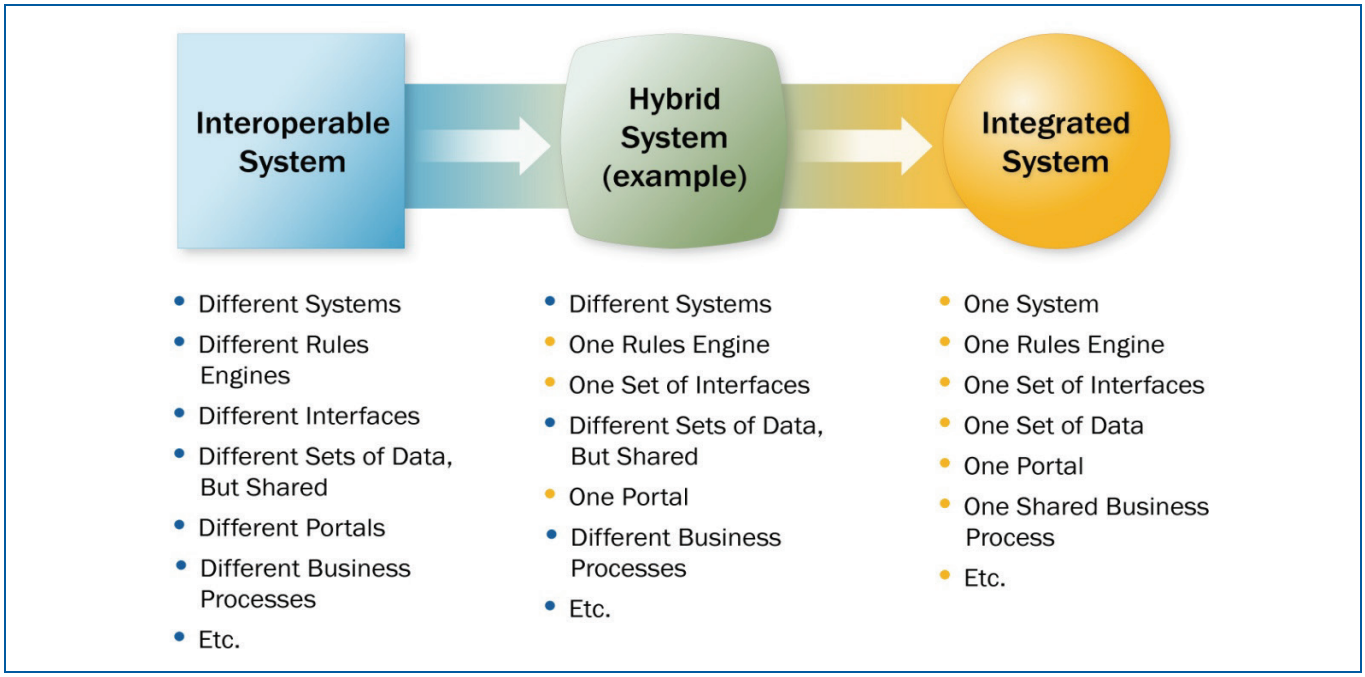
States that want to streamline the delivery of multiple benefits have a variety of options for structuring their eligibility processes and IT systems. Entities that are responsible for making eligibility determinations for the different benefits programs must perform many of the same basic functions, such as processing applications, verifying information, providing customer support, issuing benefits, dealing with changes in circumstances, and processing renewals. Many tools and services can be valuable in supporting agencies as they accomplish these tasks, including IT eligibility and/or case management systems, rules engines, call centers, application processing centers, data imaging, and online self-service portals.

To the extent states share the tools, services, and staff among benefit programs in a way that links consumers to all benefits they qualify for, the state is implementing an **integrated model** for service delivery. However, the integrated model is not the only way to ensure that consumers can access a full range of benefits (see Figure 3).

States can maintain separate tools, services, and staff for individual benefit programs but connect consumers to all benefit programs using an **interoperable model** for service delivery. This model requires states to use electronic bridges that can securely and efficiently share consumer information.

States can also use a **hybrid model** for service delivery by sharing some tools, services, and staff while keeping other functions separate but electronically connected in a way that ensures access across benefits. For example, a state may choose to maintain one portal through which consumers can access all health and human services programs, but once entered, information for health programs is housed separately from information for human services programs. Alternatively, a state could house all health and human services data in one system, but have separate rules engines and business processes for those programs.

Figure 3. States Have Multiple Options for Streamlining the Delivery of Multiple Benefits



Source: Jim Jones, Sellers Dorsey.

Key Questions to Address in Designing a Streamlined Process

Regardless of the model a state chooses, states need to address several key questions to ensure that processes are integrated across programs:

- For low-income families, how will states structure their major activities across programs, such as accepting applications, processing eligibility and benefits, and answering questions?
- Will low-income families have to undergo multiple application processes to receive a package of benefits? When a low-income family applies for one program, will they learn about other benefits for which they may be eligible? How will they get connected to those other programs?
- Who will have access to which programs' application and verification systems? Will information in one program be used to verify eligibility or update information for another program?
- What functions will be centralized and what functions will be delivered in different local or regional offices around the state?
- When work is shared across tasks, or agencies, or programs, how will hand-off's work and how will accountability be maintained?
- Will workers will be trained across multiple programs for all tasks, or will some tasks or some types of families be specialized?
- What roles will be filled by technology (online, telephone, etc.) and where will human involvement be crucial? How will families get their questions answered when technology alone is not sufficient?
- How will policy officials and managers know if the process is working?

Implementing the Vision: About This Toolkit

As states approach the question of how to implement the ACA's coverage expansion, they face numerous questions about how to structure their processes and workforce, and how to use technology and other resources within federal rules. This toolkit is designed to help states sort through those choices. Specifically, it is intended to guide states in developing an eligibility system and process that meets the standards and requirements of the ACA, with a particular focus on ensuring that poor or near-poor families have a way to access the full package of available benefits. It raises issues and questions that states need to consider to ensure that these families' experience with obtaining benefits is not only protected, but improved, as states modify and upgrade their systems.

Since Medicaid is the health coverage program for which most poor and near-poor families will qualify, this toolkit deals primarily with the Medicaid expansion. This toolkit does not, however, address all aspects of expanding Medicaid. For example, it does not touch upon the development of the benefit package that will be provided to the expansion population or the work that states will have to do to ensure a sufficient number of providers exist to serve all those who will newly enroll in Medicaid. Rather, it focuses on the key task of getting people enrolled into health coverage through an efficient and effective system that also connects them to the other benefits and services for which they qualify.

What Is Covered in the Toolkit?

Each section of this toolkit provides states with tools and suggestions for a guided process that can be used to review the current eligibility and enrollment service delivery model and compare the current model to the desired future model. The toolkit includes the following topics:

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- **Applications.** This module will help states take stock of how well their current applications perform in order to identify additional improvements that should be incorporated in the design of a new, ACA-compliant application. It will also help states identify questions that would need to be added to a Medicaid application to make it a multi-benefit application that can also be used for SNAP and other human services programs.
- **Verifications.** This module helps states identify opportunities for streamlining verification policies and processes across programs. It starts with a review of states' current verification practices and walks through issues that states should consider in designing a verification process that minimizes the burden on families.
- **Renewals.** This module provides a framework for a guided process that state agencies can use to review how they currently conduct renewals, and design a new process to meet the ACA requirements.
- **Staff Readiness.** This module will help states assess their current staffing model, including taking an inventory of their current position descriptions, organizational structure, performance management system and staff training.
- **Project Management and Communications.** This module provides states with tools to kickoff their planning for ACA implementation. It walks through how to create an outline of a project plan, define team

members' roles and responsibilities, develop a project calendar, and create an outline of a communication plan.

It should be noted that this toolkit does not include a section on technology, which is a critical component of ACA implementation. This toolkit assumes that the development and procurement of the new systems that will support Medicaid eligibility and enrollment is likely well underway in many states. Instead the toolkit focuses on the other systems and processes that the technology will support.

To simplify the toolkit and the design of the exercises, this package mostly focuses on integrating the delivery of Medicaid and SNAP benefits — the two largest programs that states generally co-administer. But states are encouraged to consider and include other programs. This toolkit highlights Medicaid and SNAP because they present the most immediately available and highest-impact opportunities for many states: a great deal of participant overlap exists in these programs, and they serve the greatest number of low-income families. However, the full package of supports for low-income families is extensive, including child care assistance, cash assistance and other services offered through the Temporary Assistance for Needy Families (TANF) block grant, housing vouchers, Low Income Home Energy Assistance (LIHEAP), and the Earned Income Tax Credit, among others. States that want to include these other programs in their integration efforts should do so. Much of the issues for consideration raised in this toolkit are also applicable to the coordination of other benefit programs with Medicaid.

Who Needs to be Involved?

A successful planning process reaches the broadest group of stakeholders possible, including community organizations and clients. To complete most sections of this toolkit, it will be important to invite representatives from the following stakeholder groups:

- Policy officials from agency leadership and/or Governor's staff
- Policy staff representing each program you plan to include (e.g., Medicaid, CHIP, SNAP, child care, TANF)
- Staff from the state's health reform governing organization
- Operations experts, such as field supervisors and caseworkers
- IT analysts, particularly those knowledgeable around your planned IT changes under the ACA
- Human resources experts
- Outreach staff
- Communications experts
- Community-based organizations — especially those involved in outreach
- Advocates
- Clients

Individuals who represent these perspectives can be included from the beginning or brought in later in the process as appropriate. For each module of the toolkit, also consider including other people with more in-depth expertise on the particular topic that is being addressed. This toolkit is written for those with knowledge about program rules and processes and assumes the involvement of those who are engaged in ACA planning and have knowledge of ACA requirements.

What Types of Policy and Process Information Will Be Needed?

Each of the modules requires states to go through an assessment of current processes to identify what works and what doesn't, changes that need to be made to comply with the ACA requirements, and improvements that that will help states deliver benefits in a more streamlined fashion. Conducting these assessments requires information about federal and state requirements, as well as state-specific policies and processes that are currently in place. Table 1 lists some of these background materials.

In most instances, materials will be useful to completing several sections. For example, information on current worker processes and procedures for the benefit programs being reviewed will be useful for completing the applications, eligibility, verifications, and renewals sections. It is recommended that these materials be collected and distributed workgroup members in advance to maximize the productivity of workgroup discussions.

Using this Toolkit

This toolkit is intended to help ensure that state efforts to implement health reform factor in the delivery of other services provided to states' lowest income households. The modules that follow are structured to guide states through the task of designing the various elements of a system for determining eligibility for Medicaid, SNAP, and other benefit programs. It is meant as a template to help guide state efforts. In many cases, states will need to tailor the exercises to meet their specific needs.

Providing Feedback on This Toolkit

We value your feedback and would like to hear from you about ways that we can refine this toolkit and make it more useful. Tell us what you used, what you liked, what you didn't like, and what could be improved. Please send comments and suggestions to Carolyn Jones at jones@cbpp.org.

Each module provides context on the importance of the topic being addressed and how a state's decision on the issue can impact a family's ability to access multiple benefits. Each module also contains instructions on how to complete the section, including what materials and resources are needed, suggestions for information or data that should be gathered in advance, as well as estimates of the amount of time and effort that you might consider devoting to the process. While the topics covered in each of the sections are interrelated, each section is designed to stand on its own, so that states can complete only certain sections if they so choose.

Finally, the Center on Budget and Policy Priorities is available to work with state and local agencies on using this toolkit. We can help you design planning sessions that work for your state agency and have some availability for on-site facilitation. Please feel free to contact us to discuss this option.

Table 1. Background Materials Suggested to Support Planning Efforts

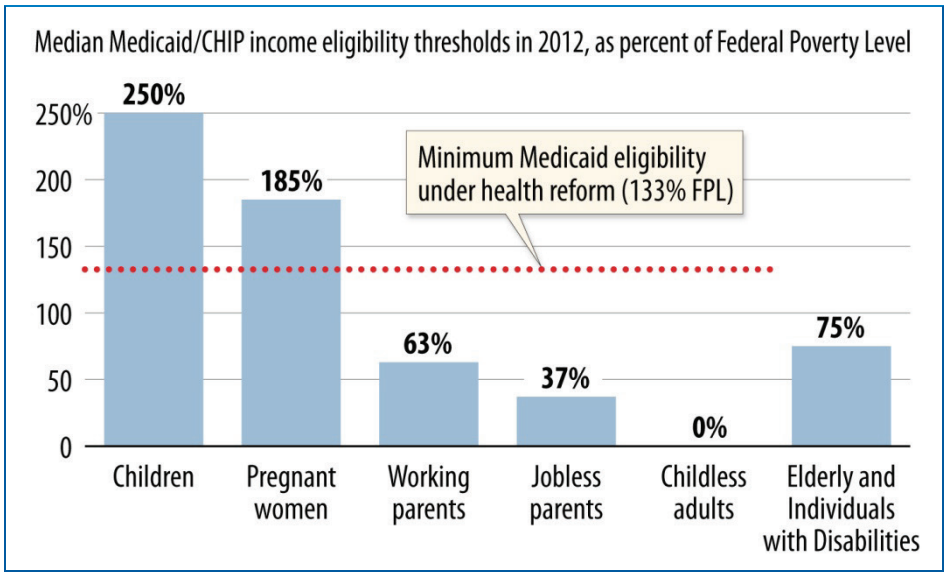
	Eligibility Process	Applications	Verifications	Renewals	Staffing Model	Project Management and Communications
Example Forms and Client Communications						
Copies of all current paper applications		X				
Access to all current online applications		X				
Copies of verification forms clients are required to submit (e.g., landlord form, employer statement, etc.)		X	X			
Policies, Procedures, and Systems Manuals						
Access to current worker processes and system(s) procedures for Medicaid, CHIP, SNAP, and other applicable programs	X	X	X	X		
Access (electronically, if possible) to current administrative rules for Medicaid, CHIP, SNAP, and other applicable programs	X	X	X	X		
Descriptions of current electronic interfaces and other forms of electronic verifications (e.g., The Work Number/TALX)			X			
Access to new Medicaid rules for ACA	X	X	X	X	X	
Side-by-side comparison of Medicaid and SNAP federal rules (provided in Applications, Verifications and Renewals Appendices)		X	X	X		
High-level picture of new service delivery model	X		X	X	X	
Data and Reports						
Data on types of applications/renewal forms being submitted (online vs. paper)		X		X		
Data on most common types of paper verification submitted by clients			X			
Recent SNAP Quality Control data on errors related to verification, especially income			X			
Administrative data on Medicaid renewals				X		
Data on program overlap	X			X		
Human Resources and Project Documents						
Current position descriptions for eligibility and clerical staff					X	
Current organizational charts and staffing levels					X	
Current staffing performance reports and tools (e.g., annual review forms)					X	
Current training curriculum outline, training plan, and evaluation data					X	
Project Charter template (provided in Project Management and Communications Appendix)						X
Communications Plan template (provided in Project Management and Communications Appendix)						X

Eligibility Process

Background

Beginning in 2014, the number of low-income people eligible for Medicaid will expand dramatically. As Figure 1 shows, currently, adults without dependent children generally do not qualify currently for Medicaid (except in a few states that have extended coverage through waivers), and parents are eligible only if their income is very low. But starting in 2014, all states will have to provide Medicaid coverage to most individuals with incomes up to 133 percent of the poverty line.[8]

Figure 4. Most People With Incomes Up to 133% of the FPL Will Qualify for Medicaid in 2014



Source: Based on information gathered during a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Those with incomes above the Medicaid or Children's Health Insurance Program (CHIP) upper income limits will also have the opportunity to purchase insurance through exchanges and may be able to offset the cost of coverage if they qualify for advance premium tax credits (APTC) and cost-sharing subsidies. Altogether, by 2021 an estimated 33 million people who would otherwise be uninsured are expected to have coverage, with Medicaid, CHIP, and the premium tax credits playing a significant role in achieving this reduction in the number of uninsured.

To cover as many eligible individuals as possible, it is expected that consumers will have access to a seamless, streamlined, "no wrong door" process for accessing and maintaining their participation in Medicaid, CHIP, and the premium tax credits. This will be no easy task, considering that families may have individuals within a household who are eligible for different health subsidies, or their circumstances may fluctuate and

[8] In determining eligibility, income equal to 5 percent of the poverty line is disregarded. Thus, the effective minimum income standard for Medicaid will be 138 percent of the poverty line.

necessitate frequent redeterminations. New rules will require states to make changes to their eligibility processes to achieve a streamlined and simplified system across health insurance affordability programs. States must create eligibility processes that will:

- Provide a "no wrong door" experience for consumers at initial enrollment. It is unlikely that consumers will know which health insurance affordability program they qualify for when they seek services. Consumers must be able to provide their information one time and be enrolled in the appropriate program regardless of where and how they apply for coverage. This approach was taken from Massachusetts, which has one application form for multiple health coverage programs, and the Medicaid agency evaluates each form and sorts the consumer into the appropriate program, including programs run by other agencies.
- Provide beneficiaries the opportunity to report changes in their circumstances and, if necessary, ensure that individuals make smooth transitions between programs.

This will be a change in some states where enrollment procedures can seem as if consumers must know what program they want when they apply. For example, in some states that administer CHIP and Medicaid separately, if consumers apply through Medicaid but are eligible for CHIP, the state may refer them to CHIP but it does not transfer their information electronically and may even require them to complete and submit a new application. The new vision for eligibility will allow consumers to apply using one form; the state will guide consumers to their available choices based on their eligibility and transfer data electronically to other agencies as needed.

In creating the "no wrong door" for health insurance affordability programs, states can build on lessons learned from their experiences in implementing CHIP. States that that simply expanded Medicaid eligibility using CHIP funding and those that jointly administer the eligibility processes for Medicaid and CHIP have less hand-offs and file transfers to be concerned about. Those that operate separate Medicaid and CHIP eligibility structures have had to create mechanisms to appropriately "screen" and enroll children at initial intake, renewal, and during periodic redeterminations. Some states, like California, have created ways to expedite coverage during transfers between agencies. For example, the California agency that administers CHIP is able to make presumptive eligibility determinations to expedite access to benefits whenever a Medicaid-eligible child becomes known to CHIP.

How Will Health Reform Change Medicaid Eligibility Rules?

To coordinate eligibility and coverage across the different health care programs, states will make major changes in the way they determine eligibility for Medicaid and CHIP in 2014. The biggest changes involve how income and household size are defined to determine eligibility for most people in Medicaid and CHIP (as well as premium credits to purchase coverage in the exchange).

The health reform law establishes a new method — called Modified Adjusted Gross Income, or MAGI — for calculating income and household size to determine Medicaid and CHIP eligibility. The use of MAGI is necessary to standardize and simplify income eligibility across states and among Medicaid, CHIP, and the exchange premium subsidies. Detailed information about how MAGI compares to current Medicaid, and a comparison between MAGI and SNAP can be found in Appendix 1.1.

States will need to consider how these changes will affect coordination with SNAP and other benefits. There currently are differences between SNAP's income and household definitions and those used in Medicaid and CHIP, so to some extent these types of differences are not new. Also, the move to automated collection of families' information through the health exchanges and online public benefit applications, as well as the use of "rules engines" for determining eligibility, will allow states to use technology to simplify some of the more complex rules regarding income counting and unit composition.

Moving forward, states will have many choices about how to structure eligibility for each insurance affordability program. The greater the number of agencies involved in processing eligibility, the more imperative it will be to ensure that the processes and technology will ensure that consumers can access "no wrong door" to obtain health coverage.

Furthermore, many of the individuals who will be eligible for Medicaid will also be participating in other programs, such as SNAP. As states face the great workload challenge to meet the needs of those newly eligible for Medicaid, they may wish to consider how they can extend the "no wrong door" approach beyond health programs to help individuals access the full scope of human services benefits.

Although most states have a long history of using the same workforce and technology to serve individuals across benefit programs, some states have felt the urgency to prioritize their ACA planning to ensure coordination between Medicaid and the newly created health insurance exchanges. While this coordination is vital, it is also important that states pay attention to how eligibility across all benefit programs will be coordinated, to ensure that the most vulnerable individuals are connected to the full range of services for which they are eligible — and that states avoid costly duplication of effort among staff. It's also important to note that to the extent states have administered their Medicaid and/or CHIP programs together with other non-health benefit programs in the past, the changes required of Medicaid and CHIP will necessitate program changes for the non-health programs regardless of a state's decision to keep these programs integrated. For example, if a state previously had a multi-benefit program that included Medicaid, that application will have to change to meet new requirements.

Changes in the ACA require states to decide how their eligibility processes and structures will operate in 2014 and beyond. This module will help facilitate discussion to better prepare states to make decisions related to ACA implementation and its impact on overall benefit delivery across the state. Decisions states make about how to structure their eligibility processes across programs will affect every aspect of work covered in this toolkit.

Goals

This module of the toolkit will help your team:

- Take stock of its current eligibility processes.
- Identify what needs to be done to ensure that consumers can access "no wrong door" to health and human services programs in 2014.
- Identify how to coordinate eligibility across programs.
- Identify the major functions, services, and/or tools that can be shared across programs.

Tools

The following tools are included in this module:

1. **Presentation:** Eligibility and coordination requirements under ACA.
2. **Exercise 1:** Scan of current eligibility processes for health and human services programs in the state and ways in which current processes can be improved.
3. **Exercise 2:** Identify what needs to be done to ensure that consumers can access a "no wrong door" in 2014.

4. **Exercise 3:** Identify key functions and tools that can be shared across programs.
5. **Wrap-Up and Next Steps:** Identify eligibility structure and decisions and how the structure will affect other implementation requirements including: development of applications, verifications, renewals, staffing, etc.

How to Complete this Module

First, you will want to think about whom to involve in a workgroup focused on your eligibility processes. Involving a diverse group of experts, decision makers and stakeholders will ensure that your group discussions consider all aspects of the work. You may want to consider including the following representatives:

- Medicaid, CHIP, SNAP, and other policy experts
- Representatives from your state's exchange agency
- Operational managers from field offices
- Representatives of eligibility staff and/or labor unions
- Quality assurance representatives
- Data analysts familiar with your data file
- State and/or vendor IT experts

If resources allow, you may also want to involve an outside facilitator. At the end of this section, we suggest additional background materials you may want to distribute to the group.

Each of the exercises involves holding one or more workgroup meetings. Questions have been provided in each exercise to guide your conversations, but your group should add or substitute questions as you see fit to meet your needs. As you work through discussion questions, make sure to take note of key decisions, unresolved issues that need further attention, and action steps that need to be taken to move forward with planning and implementation.

We estimate you will need approximately eight hours of workgroup meetings to complete this section. You may choose to schedule them in a series of shorter meetings or one all-day session. Feel free to modify the exercises in this section to meet your specific needs and address local conditions.

Presentation

Eligibility and coordination requirements under the ACA

To design your new system, all members of your workgroup will need to be familiar with the ACA requirements for determining eligibility. As such, we recommend starting with a presentation covering these new requirements to establish the expectations for what the eligibility system must be able to accomplish in 2014. It's likely that workgroup members who focus on Medicaid policy will be more familiar with these new requirements than others. In such cases, you may want to consider having your Medicaid or health reform experts give the presentation.

The presentation should start with a high-level vision for how eligibility determinations and enrollment in health coverage are supposed to be accomplished in 2014. PowerPoint slides (with notes) for this presentation are provided in Appendix 1.2. Feel free to modify this presentation to suit your workgroup members' current knowledge level, but at a minimum, the presentation should cover the following issues:.

- States are required to develop a "no wrong door" eligibility process (application, renewal and change reporting) that minimizes the burden on consumers, and allows them to apply for all applicable insurance affordability programs using a single, streamlined application.
- The system must be seamless and allow different programs to share applicant information through secure interfaces, as well as maximize the use of technology to facilitate eligibility determinations and minimize the need for paper documentation.
- States are also required to provide processes that allow consumers to submit applications and renewals through the mail, in person, by telephone, and online (further discussed in the Applications and Renewals modules of this toolkit).
- There are many ways that states can set up their eligibility systems and processes to meet the expectations and requirements of the ACA. States can develop an integrated system in which the same entity processes eligibility across all programs. They can implement an interoperable system in which separate entities process eligibility but consumer cases are transferred seamlessly through secure interfaces. States can also implement a hybrid system in which some services, such as a rules engine, are shared between separate entities that are responsible for eligibility for different programs, and information is transferred seamlessly between the entities.
- For a limited time only, enhanced federal matching dollars, covering between 90 and 100 percent of all costs, are available to fund IT investments that improve eligibility determinations for Medicaid. Thanks to a special waiver from normal cost-allocation rules, human services programs are not required to contribute to the cost of these investments, even if such programs benefit.

Exercise 1

Scan of current eligibility processes for health and human services programs

This first exercise will help your workgroup get a common understanding of how well the state's current eligibility structure and practices are working to ensure that individuals and families are connecting to all health and human services programs. All team members should become aware of the state's track record in connecting individuals to benefits, which entities are currently responsible for processing eligibility, and the current processes for making referrals and sharing information among agencies. This initial scan will help your workgroup identify current successful practices to build on as well as existing gaps that may be filled as the state contemplates changes related to ACA.

Gathering Background Information

The first step in this process is to gather background information that will be helpful to provide to workgroup members. In advance of your first workgroup session, each program area represented on your team (e.g., child care, SNAP, Medicaid, exchange, etc.) should designate one representative to participate in a data collection group. This group should allow for an appropriate amount of lead time, which will depend on your state's ability to quickly extract data from the relevant eligibility systems. We recommend having the workgroup members responsible for this assignment present their findings at the first workgroup meeting.

Using Table 1 below, identify and fill in the current income eligibility thresholds for the programs you want to integrate. Having this information will help your group understand opportunity for case overlap. If, for example, SNAP is available to those with gross income at or below 130 percent of the poverty line and Medicaid covers parents with gross incomes up to 100 percent of the poverty line, you can conclude that there is a lot of potential for case overlap, but some individuals who are eligible for SNAP will not be eligible for Medicaid.

Table 1. Current Income Eligibility Thresholds for Health and Human Services Programs

Health and Human Services Program	Applicable Income Standard (gross and/or net as applicable)
Medicaid for Children (by age group)	
Medicaid for Parents	
Medicaid for Non-Disabled, Childless Adults	
Medicaid for Aged, Blind or Disabled	
CHIP	
SNAP[9]	
TANF	
Child Care	
Other	

[9] For states that have raised the SNAP gross income limit through broad-based categorical eligibility, keep in mind that not all households up to the higher limit will qualify for a SNAP benefit. Only those with high deductible expenses will qualify.

After identifying the potential for case overlap based on income eligibility, complete Table 2 to identify actual case overlap between SNAP and Medicaid. You may wish to include additional programs such as child care or TANF.

The table below will guide your team in identifying how many families are receiving only one benefit or both. Breaking it down by income ranges will allow your team to determine current gaps in access among those who are very likely to be eligible for both or if eligibility may be a reason for a lack of overlap.

Table 2. Program Overlap by Income

	Income (for Unit Size)				
	Under 100% FPL	**101-130% FPL**	**131-150% FPL**	**Above 150% FPL**	**Total**
Number of units (without an elderly or disabled member) that have a member (or members) that receive:					
SNAP only					
Medicaid only					
SNAP and Medicaid					
Total number of units					
Share of units (without an elderly or disabled member) with a member (or members) that receive:					
SNAP only					
Medicaid only					
SNAP and Medicaid					
Total units	100%	100%	100%	100%	100%

Note: Unit definitions and income counting rules differ for SNAP and Medicaid. These differences may present challenges. States should keep in mind that the point of this activity is to identify where the state is providing multiple benefits to the same family and/or individuals and where there may be gaps in overlap. For presentation, the state may wish to use a pie chart of the percentages in the bottom panel.

The state may want to add other programs, for example child care or TANF, by similarly exploring the SNAP and Medicaid coverage for families that participate in the other program.

After gathering information about case overlap, use Table 3 to indicate which agencies or entities currently determine eligibility for each benefit program. This will help the team identify the entities with which consumers are interacting to receive and stay enrolled in benefit programs. For example, in states with separate agencies for CHIP, child care, and SNAP, a family seeking benefits may interact with three separate agencies. Consequently, state workers from each of the three agencies may be collecting much of the same information from the family, and there may or may not be processes in place to make referrals among agencies.

Table 3. Agencies Involved in Determining Eligibility for Health and Human Services Programs

	Medicaid for Children and Families	All Other Medicaid	CHIP	SNAP	TANF	Child Care Subsidies	Other
Human Services Agency							
State Medicaid Agency							
Separate CHIP Entity							
Counties							
Other (Specify):							
Other (Specify):							

Conducting Workgroup Meetings

The second step in this exercise is to schedule one or two workgroup meetings (depending on length) to reflect on the data that has been gathered and have a discussion around current program overlap, process overlap, and areas for improvement. Below we provide a series of questions about each of these issue areas to help guide your discussions. We estimate it will take a total of approximately four hours to discuss all of the questions.

The first set of questions focuses on helping you analyze the data on case overlap among programs that you gathered in completing Table 2. You can discuss these questions as a large group or by dividing into small groups to discuss and answer questions, followed by a report-back session coupled with a full workgroup discussion. It may also be helpful to identify specific examples to support the group's answers to the questions.

Discussion Questions on Program Caseload Overlap

Key Questions: *Where is there most joint program participation? Why does this exist, (i.e. does your state deem all TANF participants to be eligible for SNAP)? Is it attributable to any specific practices? If so, what practices?*

Key Discussion Points:

Key Questions: *Where is there least amount of joint program participation? What can this be attributed to? Are there steps that can be taken to address this issue?*

Key Discussion Points:

After your workgroup has answered the program caseload overlap questions, it will be ready to discuss how information currently flows among and within agencies. Using Table 3 as a starting place, the following questions can guide your discussion about how your state processes and IT systems currently overlap and coordinate to provide consumers with the full scope of benefits:

Process Overlap and Coordination Discussion Questions

Key Questions: *Based on information in Table 3, can a low-income family's data be in more than one eligibility IT system? If yes, how many?*

Do any of these eligibility IT systems interface electronically to one another?

Is there look-up capability among programs? For example, can Medicaid look at SNAP data to complete data-driven renewals?

Key Discussion Points:

Key Questions:

In cases where different entities are responsible for eligibility processes for different programs, describe what has been done (if anything) to coordinate, refer, or otherwise connect individuals eligible for multiple programs. For example, if there is a separate eligibility structure for CHIP, how are referrals and transfers completed for Medicaid?

Are individuals enrolled in SNAP automatically eligible for other programs such as LIHEAP or child care?

Has the state tried any options like Express Lane Eligibility (a children's health option to use findings from other benefit programs to verify an eligibility factor requiring any re-calculation to account for differences in methodology) to connect consumers to other programs? If so, how it has worked? What have been the outcomes and lessons learned?

Key Discussion Points:

Key Questions:

In cases where the same entity is responsible for eligibility processing of a subset or all of these programs, how are consumers assessed for eligibility across all benefits?

Are there situations where individuals are only assessed for one program (i.e. they complete an application that only provides a pathway to one program or only indicate interest in applying for one program on a multi-benefit application?

What barriers exist to connecting individuals across a full set of benefits?

What successes has the state experienced?

Key Discussion Points:

After coming to a common understanding of how eligibility processes overlap and are coordinated, the workgroup will be ready to discuss how current processes can be improved. The discussion questions below should help to guide your conversation.

Process Improvement Discussion Questions

Key Question: *What processes have worked best and should be retained and/or expanded?*

Key Discussion Points:

Key Question: *Where are the greatest opportunities for improving current coordination and eligibility processes?*

Key Discussion Points:

Key Questions: *Have improvements to coordination been tried in the past? If so, what were the results?*

Key Discussion Points:

Key Questions: *What barriers have prevented past improvements in overall processes? How can these barriers be addressed?*

Key Discussion Points:

Exercise 2

Identify what needs to be done to ensure that consumers have a "no wrong door" experience when accessing health and human services programs in 2014

In Exercise 1, the workgroup identified strengths and weaknesses in current eligibility practices and processes that aim to connect individuals and families to health and human services programs. The challenges, gaps, and successes identified should be kept in mind as the team completes Exercise 2, which is focused on designing the eligibility processes to ensure that there is a "no wrong door" experience for consumers in states that do not choose to fully integrate all of their health and human services programs.

The ACA requires that states make changes to current Medicaid and CHIP programs to ensure coordination with the health benefits exchanges. It also provides states with new options for structuring their eligibility for Medicaid and CHIP. For example, states can now delegate all Medicaid eligibility processing to a state-based exchange (under certain conditions). States must decide which entities will process eligibility for Modified Adjusted Gross Income- (MAGI) based Medicaid, non-MAGI-based Medicaid, CHIP, Advance Premium Tax Credits (APTC) and cost sharing subsidies, as well as other state health programs.

Conducting a Workgroup Meeting on Program Coordination

If your state decides to have more than one entity process eligibility for health and human services programs, you will want to schedule another workgroup meeting of approximately two hours to discuss coordination issues. The discussion questions below will help frame your conversation. Because this discussion is largely focused on operational issues, you may want to adjust your workgroup membership to make sure you have appropriate representation from the work units that will be affected. If you have the facilitation resources, you might also want to develop a process map that describes how some of these hand-offs will occur.

Program Coordination Discussion Questions

Key Question:	*Which entities will process and/or maintain eligibility for each program (non-MAGI-based Medicaid, MAGI-based Medicaid, CHIP, APTC, SNAP, Child Care, TANF, etc.)?*
Key Discussion Points:	

Key Question:	*How will each entity complete a screening to identify those eligible for a program other than the one they are determining? Will they use all of the same policies and verifications?*
Key Discussion Points:	

Key Question:	*What information will be transferred between agencies?*
Key Discussion Points:	

Key Question:	*How will files be transferred between agencies?*
Key Discussion Points:	

Key Question:	*What timeliness standards and other accountability measures will be put in place for the transfer of files and the ultimate determination of eligibility?*
Key Discussion Points:	

Key Question:	*How will disputes be resolved when entities disagree about determinations?*
Key Discussion Points:	

Key Questions:	*Will all state entities operate the same IT eligibility system? If not, how will cases be transferred and what IT functionality will be needed to make data transfers occur securely and seamlessly?*
Key Discussion Points:	

Exercise 3

Identify key functions and tools that can be shared across programs

All health and human services programs must complete certain key functions to serve clients. They must have mechanisms in place to accept and process applications and changes reported by clients, and to initiate and process renewals. States use a variety of tools to accomplish these functions, including call centers, centralized processing centers, online portals and customer service centers that allow for in-person help. Regardless of how your state allocates eligibility processing responsibility to different entities, opportunities to share these tools may exist.

Gathering Background Information

The first step in Exercise 3 is to gather some background information for a subsequent workgroup discussion on which benefit programs have, need, or could benefit from the various tools available to process applications, changes in circumstances, and renewals. Use the table below to determine where different benefit programs have overlapping uses or needs for call centers, online portals, centralized processing centers, in-person customer service, etc.

Table 4. Program Use of Tools and Services for Various Eligibility Functions

	Call Centers	Online Consumer Facing Portals	Centralized Processing Center	In-Person Customer Services	Other (mail, IVR, online chat, , etc.)
	List of programs that have, need, or want this tool				
Accept and process applications (including verification)					
Accept and process changes					
Send/process renewals					

Conducting Workgroup Meetings

After completing the inventory of the tools that benefit programs currently have and/or need, the second step is to have a workgroup discussion about how to make these services available, and which of these services can be shared among programs (each of these functions is discussed in further detail in other modules of this toolkit; this module will help states make high-level decisions about these processes to inform later activities). You should be able to complete this in one workgroup meeting of no more than two hours. Below are discussion questions you may use to facilitate a workgroup conversation about sharing services.

Shared Services Discussion Questions

Key Questions:

Can the human services office fulfill the in-person access requirement for Medicaid programs and CHIP? What about for Exchange programs?

What would be needed in terms of staffing? Training? Technology?

Key Discussion Points:

Key Questions:

How can the online application be designed to be a pathway to all human services rather than just health subsidies?

If the state is using separate staff and eligibility systems, what needs to be done to program the application to send only necessary information to each entity?

Will consumers be given the option to select all programs they are interested in upfront in the application, at the end, or a combination of both?

Key Discussion Points:

Key Questions:

Will the state have multiple call centers for each individual program? Which programs can share call centers? What are the main duties of the call centers?

What IT systems will be needed to support call centers? How will calls be screened and triaged? Will you take a first-contact resolution approach?

What staffing, training, and technology needs do you have to consider?

Key Discussion Points:

Key Questions:

Who will process applications, changes, and renewals completed by mail?

What staffing, training, and technology needs do you have to consider?

Key Discussion Points:

Key Questions:

How will IT work together to ensure that the systems can work together and seamlessly share information?

Will the state share a rules engine or other key IT components and/or functionality such as data imaging or a data warehouse?

Key Discussion Points:

Key Questions:

Will the state operate one or multiple IT eligibility systems?

If multiple, what information will be shared and transferred among systems? Which systems will be sharing information?

What data sharing agreements need to be in place? Who will negotiate those agreements?

Key Discussion Points:

Key Questions: *What is the timeframe and staging for developing/updating systems in preparation for the Medicaid expansion?*

Key Discussion Points:

Key Questions: *If systems will be integrated across benefit programs, what is the timeframe for full implementation across programs?*

If implementation will be phased in, what are the plans for processing eligibility within phases?

How will the phased approach affect staff? What can be done to minimize the burden on staff while ensuring that consumers still have access to the full scope of benefits?

Will the timeframe allow for full utilization of the 90/10 match and cost allocation waiver?

Key Discussion Points:

Wrap-Up and Next Steps

Determine how eligibility will work in your state

By now your workgroup should have a common understanding of current processes, including what works well and areas for improvement, determined who will handle eligibility for health insurance programs and human services, identified next steps that need to be taken if eligibility will be processed by separate entities, and identified key functions and tools that can be shared across programs. As a final step, you may want to wrap up your last workgroup meeting by identifying the following: decisions made on the various issues discussed in the workgroups; areas where decisions still need to be made and what additional information is needed to make a decision; next steps for making additional decisions or implementing decisions already made; and the timeframe for moving the planning process along. These questions will help your workgroup finalize your eligibility processes and decisions and determine how they will affect other implementation requirements, including the development of applications, verifications, renewals, staffing, and other components of your model.

Wrap-Up Discussion Questions

Key Question: *What are your state's goals for ensuring that individuals have access to the full scope of benefits for which they are eligible?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What are your state's goals for reducing the burden on individuals to enroll in the full scope of benefits?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What coordination practices should be retained, enhanced, and/or built on (based on discussion in Exercise 1)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What processes will you put in place to ensure access to "no wrong door" for health and human services programs (based on discussion in Exercise 2)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *Which entities will make eligibility determinations for each health and human services program? For states that will not be fully integrated, which programs will be separate and how will the referral processes and data transfers work (based on discussion in Exercise 2)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What services will be shared by different programs (based on discussion in Exercise 3)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What are your high-level plans for replacing or upgrading current eligibility system(s) to meet the new Medicaid requirements (based on discussion in Exercise 3)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What changes will be made to other human services eligibility systems to integrate with or link to the new/upgraded Medicaid system (based on discussion in Exercise 3)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *If systems will be phased in to integrate multiple programs, what are your plans for processing eligibility for individuals eligible for multiple benefits in the interim (based on discussion in Exercise 3)?*

Key Decisions:

Decisions Pending:

Next Steps:

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Appendix 1.1: Comparison of Income and Household Calculation Methods for Medicaid and SNAP

In 2014, Medicaid will use a new methodology for calculating income — called Modified Adjusted Gross Income, or MAGI — in determining eligibility for most people and will keep existing rules for specific categories of coverage such as those serving the aged, blind, and disabled populations. This document highlights key differences in how SNAP and MAGI will count income and calculate household size for eligibility determinations

Income Sources

Under Medicaid today, the treatment of income depends on the category under which an individual becomes eligible for the program. States also have flexibility to disregard certain income and deduct certain expenses, which has led to significant state-by-state variation in Medicaid income counting methodologies. By contrast, under the new methodology, the treatment of income will be standardized across eligibility categories as well as across states. It will be based on MAGI, which is adjusted gross income (AGI) as determined under the tax code, *plus* social security benefits and any foreign income or tax-exempt interest that a taxpayer receives.[10] AGI includes earned income such as wages, salary, tips, and gratuities, and unearned income such as unemployment, interest, dividends, rents, and royalties.

SNAP also counts all earned income (before payroll taxes and pre-tax benefits are deducted) from all household members and sources, as well as unearned income. Generally, however, SNAP income determination includes more income sources — making it more likely that SNAP beneficiaries will qualify for Medicaid after states expand Medicaid eligibility.

The table below compares how various sources of income are counted in Medicaid today and under the MAGI methodology, and under SNAP.

Income Sources	Current Medicaid	Medicaid Using MAGI	SNAP Gross Income[11]
Earned Income: General Rule	**Mostly Included.** Includes all wages and salary of an employee, income from self employment. Medicaid disregards the first $90 of earned income and, in some cases, $30 plus one-third of the earned income not already disregarded. States can disregard additional income sources or deduct additional expenses.	**Mostly Included.** Includes all wages and salary of an employee, income from self employment. Major exceptions of earned income excluded from adjusted gross income are listed below and include certain fringe benefits and various cafeteria plan benefits. MAGI disregards 5 percentage points off the poverty line in determining income and does not allow for any other income disregards.	**Mostly Included.** Includes all wages and salary of an employee, income from self employment, training allowances from vocational and rehabilitative services programs recognized by the state or federal government. **Includes deduction of 20% of earnings.**
Self-employment	**Includes** all revenues and allows for deduction of some business expenses. Business losses are not offset against other income.	**Considers** all revenues. **Excludes or adjusts** for various business expenses, including but not limited to depreciation, business-related travel and entertainment expenses (up to a limit), purchase of capital equipment, employee pay, interest payments, and business use of a personal home. If deductions exceed income, losses can be used to offset other business income, up to a limit.	**Includes** all revenues, any gains from the sale of any capital good or equipment, payment from a roomer or boarder averaged over the whole year. **Excludes** the costs in producing the income. However, costs do not include items such as losses from previous periods, money set aside for retirements, personal expenses such as transportation to and from work and depreciation.[12] [13]

[11] States have the option to exclude income that is excluded under their TANF or family-based Medicaid (SSA sec.1931) programs. Some of the basic categories are still required, but there is opportunity for alignment.

[12] 7 CFR § 273.11

[13] States have the option to simplify self-employment income determination for SNAP by developing a method to calculate the cost of doing business and using a flat percentage, a figure based on average costs, or some other method. (AL, CA, DE, GA, ID, IN, KS, MD, MI, OK, OR, SC, SD, UT, WA, and WY use this option as of 2009, according to Food and Nutrition Services.

Income Sources	Current Medicaid	Medicaid Using MAGI	SNAP Gross Income[11]
Income used for various pre-tax benefits funded by an employee's elective salary reduction (such as flex-spending plans)	**Includes** all earned income before voluntary pre-tax benefits are deducted for employer-provided benefits.	**Does not include (with some limits)** employer contributions to employee benefits made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits. Salary reduction contributions are not actually or constructively received by the employee. Therefore, those contributions are not considered wages for that employee for federal income tax purposes.	**Includes** all earned income before voluntary pre-tax benefits are deducted for employer-provided benefits.
Unearned Income: (General Rule)	**Mostly included.** Exceptions are noted below.	**Often excluded or adjusted.** Examples of unearned income that are excluded from adjusted gross income are listed below. In general, any interest received or credited to an account that can be withdrawn is counted as income for tax purposes. Some interest, however, is non-taxable, such as interest from state or municipal bonds, interest on savings bonds used for educational purposes, and interest from exempt-interest dividends.	**Mostly included.** Exceptions include many benefits not in the form of money payable to the households, including in-kind and certain vendor payments such as public assistance vendor payments for child care, medical and energy assistance; HUD, state or local housing authority payments; third-party payments on behalf of a household using funds not owed the household; many kinds of educational assistance (loans, scholarships, and grants, though the rules are complex); and other loans due in at least 60 days.
Social Security and equivalent Tier 1 railroad benefits	**Included.**	**Included.**	**Included.**
Need-based assistance payments that are partially or fully federally funded (includes the major benefit programs)	**Depends.** States have the option to include or exclude assistance such as housing assistance.	**Excluded.**	**Included.**

Income Sources	Current Medicaid	Medicaid Using MAGI	SNAP Gross Income[11]
Child Support received	**Included.** The first $50 per month is disregarded.	**Excluded.**	**Included.**
Veterans' benefits	**Included.**	**Excluded.** Does not include in income any veterans' benefits paid under any law, regulation, or administrative practice administered by the Department of Veterans Affairs (VA). (IRS Pub. 525)	**Included** (as unearned income).
One-time payment of a personal injury award	**Included.** To the extent it is not earmarked and used for the purpose for which it is paid, e.g., monies for back medical bills resulting from accidents or injury, funeral and burial costs, replacement or repair of resources, etc.	**Excluded.**	**Excluded.**
Income tax refunds	**Excluded.** Considered a resource.	**Excluded** (with very minor exceptions). Refunds of state income taxes are included in income if a filer itemized deductions in the previous tax year and deducted their state income taxes. Most low-income people itemize only if they own homes or have large medical expenses.	**Excluded.**
Earned Income Tax Credit	**Excluded.**	**Excluded.**	**Excluded.**

Income Sources	Current Medicaid	Medicaid Using MAGI	SNAP Gross Income[11]
Workers' Compensation	**Mostly included (some exceptions).** Amounts received for wage replacement are included. Amounts earmarked and used for the purpose for which it is paid, e.g., monies for back medical bills resulting from accidents or injury, funeral and burial costs, replacement or repair of resources, etc. are excluded.	**Mostly excluded.** Amounts received as workers' compensation for an occupational sickness or injury are fully exempt from tax if they are paid under a workers' compensation act or a statute in the nature of a workers' compensation act. The exemption also applies to survivors of someone receiving workers' comp. Exemption does not apply to retirement plan benefits received based on age, length of service, or prior contributions to the plan, even if retired because of an occupational sickness or injury (26 USC 104).	**Included.**
Nonrecurring Gifts	**Included.** Large gifts and inheritances are treated as lump sum income in the month received.	**Mostly Excluded.**	**Excluded.**
Student aid	**Excluded.**	**Excluded.**	**Excluded.**
Work study	**Excluded.**	**Excluded.**	**Excluded**, under most circumstances.
Foster care payments	**Excluded.**	**Excluded** for foster care providers, payments received from a state, political subdivision, or a qualified foster care placement agency for providing care to qualified foster individuals in your home generally are not included in income. However, must include in income payments received for the care of more than five individuals age 19 or older and certain difficulty-of-care payments. (IRS Pub. 17)	**Excluded** if child is considered a boarder and excluded from the household, unless household includes child as member, in which case payments are included.

Determining Household Size

Currently under Medicaid, a state determines family size and income based on family relationships and the legal liability of household members for each other.

Under the new MAGI methodology, Medicaid will consider relationship and the composition of the tax filing unit in order to calculate household size for the purpose of determining MAGI-based financial eligibility for individuals. Generally, Medicaid will group spouses, parents, step-parents and children in determining household size for individuals. Additionally, the household of a tax filer who is not claimed as tax dependent by anyone else will include the tax filer and his/her tax dependents. Pregnant women are counted as two household members when calculating financial eligibility for the pregnant woman herself, but when determining the eligibility of other household members, states have the option of calculating the pregnant woman as either one or two individuals in determining the household's size.

For SNAP, financial eligibility for the program and benefit amounts are based on households. A SNAP household consists of individuals who live together in the same residence and who customarily purchase and prepare food together. Some related individuals must be counted in the SNAP household unit if they are living together (regardless of whether they purchase and prepare meals together); examples include spouses and children up to age 22.

Some categories of individuals are not eligible for SNAP and may not be included as a member of a SNAP household, but may meet Medicaid qualifications. These include unemployed childless adults who have exhausted their three months of SNAP benefits (unless the three-month time limit is waived in the area in which the adult lives) or have failed to meet work requirements, workers who are on strike, and intentional SNAP program violators. When an individual is excluded from a household, SNAP applies different rules to determine whether all of the excluded person's income is included in determining the household's income or whether a pro-rata portion is included. Medicaid would include income from these individuals, and they would be counted in the household size.

Students living away from home also are ineligible for SNAP and also are not counted toward the parents' household size, and their income is not assigned to the household for purposes of SNAP eligibility. Students living away from home could be eligible for Medicaid, and they would be subject to regular income and household rules in MAGI.

Undocumented immigrants are ineligible for both SNAP and Medicaid. SNAP is more inclusive than Medicaid in the eligibility of lawfully present immigrants. In general, non-citizens who entered the United States for humanitarian reasons and qualified legal immigrant adults who have been in the U.S. for at least five years meet the immigration requirement for SNAP. In addition, legal immigrant children and people receiving disability-related benefits meet the immigration requirement without having to wait five years.[14] The ACA does not change current federal immigrant eligibility restrictions

[14] Stacy Dean and Dorothy Rosenbaum, "Implementing New Changes to the Food Stamp Program: A Provision by Provision Analysis of the 2002 Farm Bill," Center on Budget and Policy Priorities, August 2002, pp. 17-20, http://www.cbpp.org/8-27-02fa.pdf.

for Medicaid. These restrictions include a five-year waiting period for most lawfully residing immigrants before they can qualify for Medicaid.[15] Some states have taken the option to eliminate the five-year wait for lawfully residing immigrant children and pregnant women.

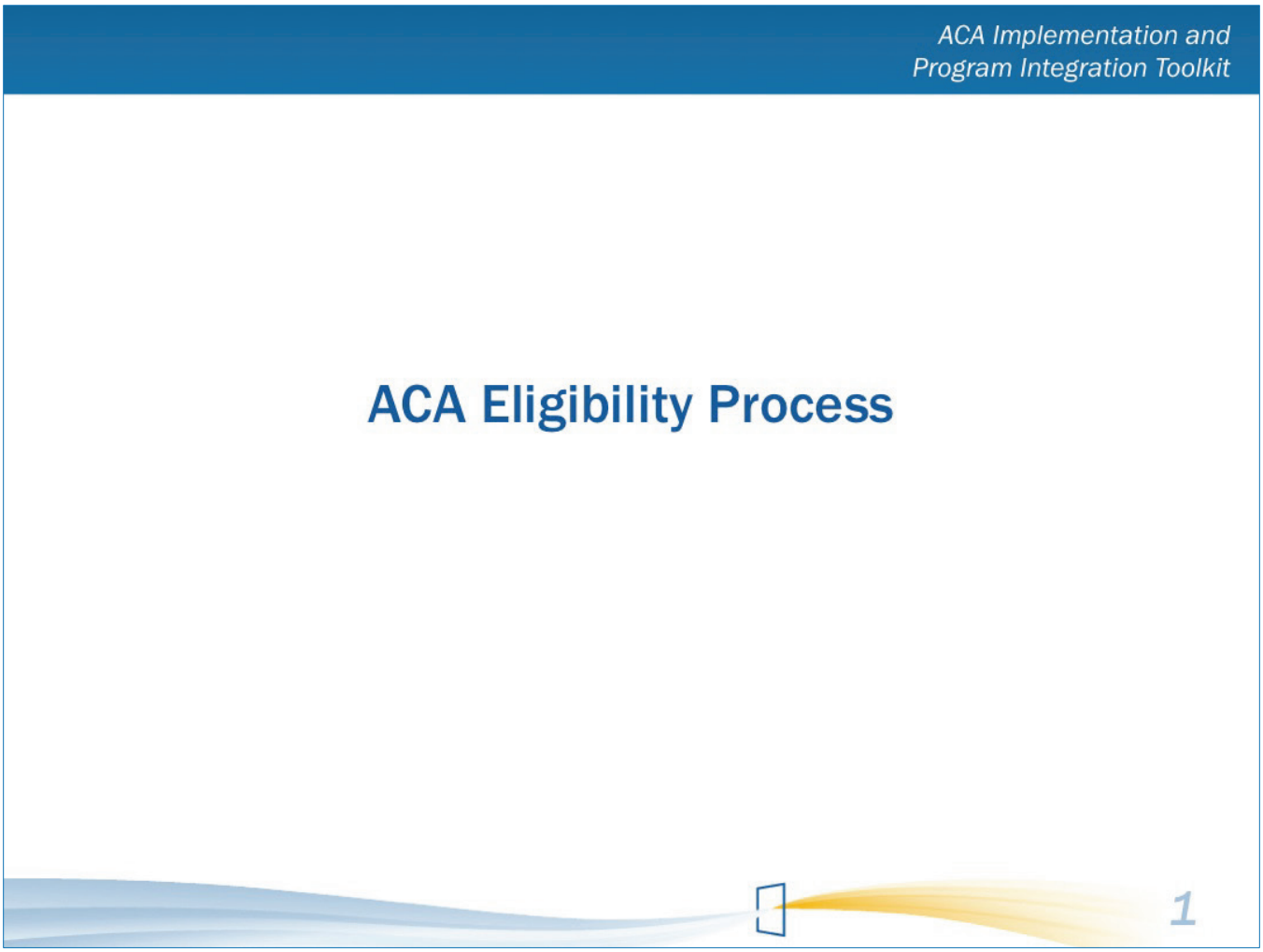
Both SNAP and Medicaid have special income counting rules for households that include both eligible and ineligible individuals based on their citizenship or immigration status (mixed-status families). SNAP gives states options for counting the income of ineligible immigrants and people not wishing to disclose their immigration status; all but three states have taken an option that counts a prorated amount of such as individual's income toward the household income.[16] If Medicaid uses the income-counting methodology that will be used to determine the income of mixed-status families for premium credits, Medicaid will establish the poverty status of a family by comparing a reduced family income to the poverty threshold for the family size excluding the ineligible family members. Family income would be reduced by the ratio of the poverty threshold appropriate to the family size *excluding* ineligible members to the poverty threshold appropriate to the family size *including* ineligible members. These differences would result in Medicaid counting a larger share of an ineligible immigrant's income toward the family's income than SNAP does.[17]

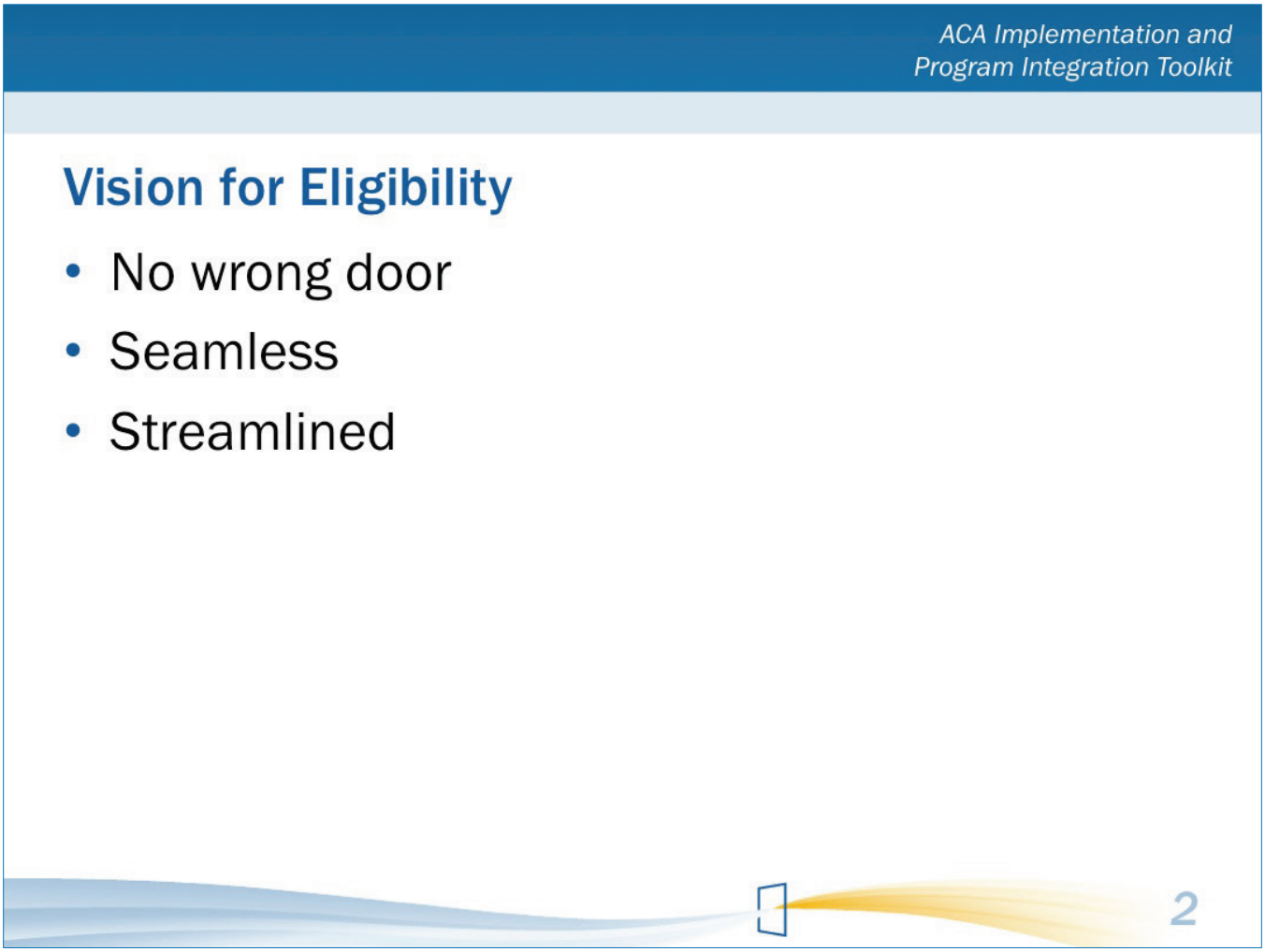
[15] Title XXI of the SSA as amended by Section 214 Children's Health Insurance Program Reauthorization Act of 2009.

[16] United States Department of Agriculture, "Supplemental Nutrition Assistance Program State Options Report: Eight Edition," http://www.fns.usda.gov/snap/rules/Memo/Support/State_Options/8-State_Options.pdf

[17] This assumes Medicaid will align its methodology with the required methodology for counting income for premium credits, as defined in Section 1402 (e) of the Patient Protection and Affordable Care Act.

Appendix 1.2: PowerPoint Presentation on ACA Eligibility Process Requirements

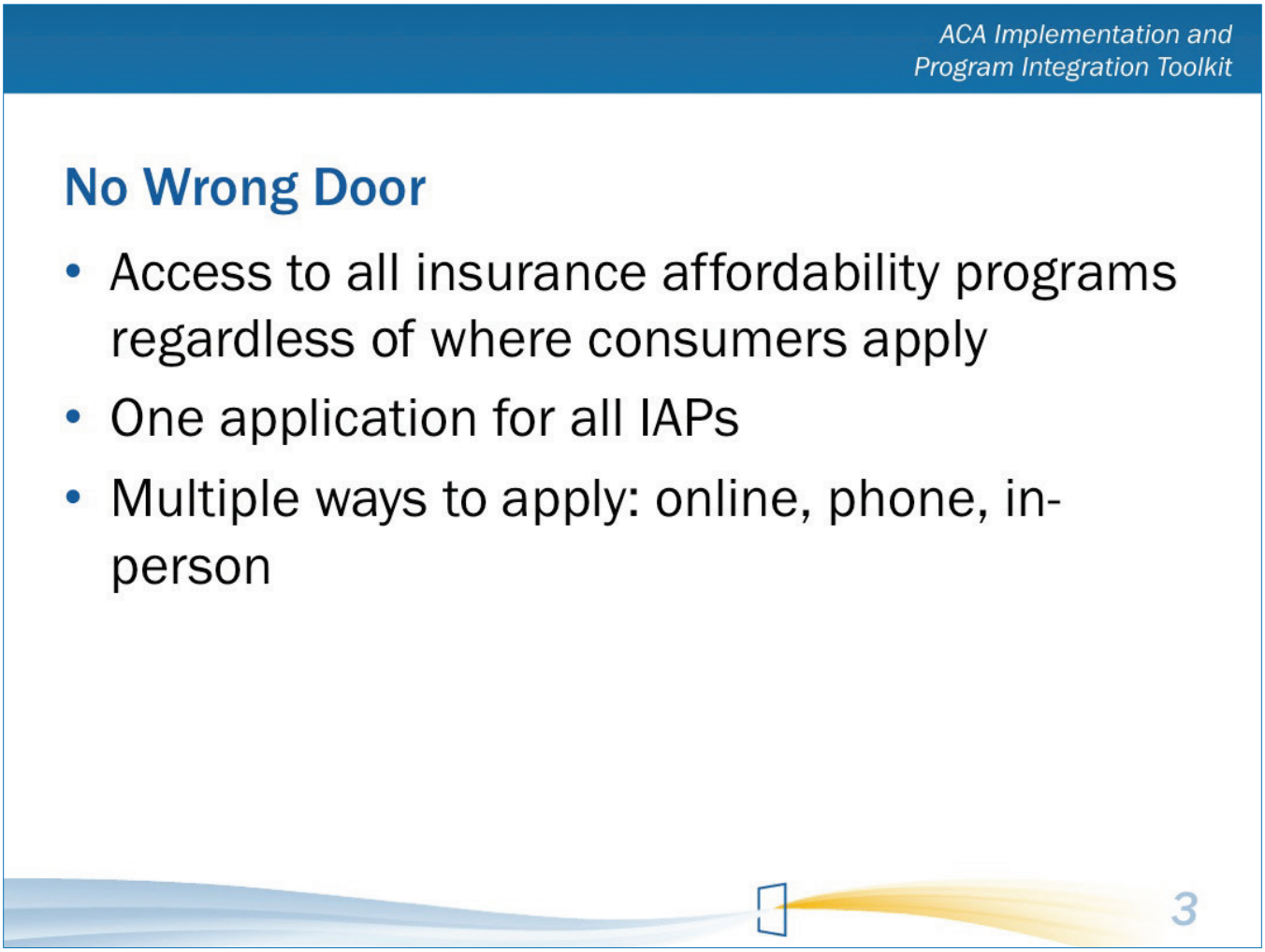




It is envisioned that the eligibility process for health insurance coverage will provide a 21st Century, first in class consumer experience. This includes:

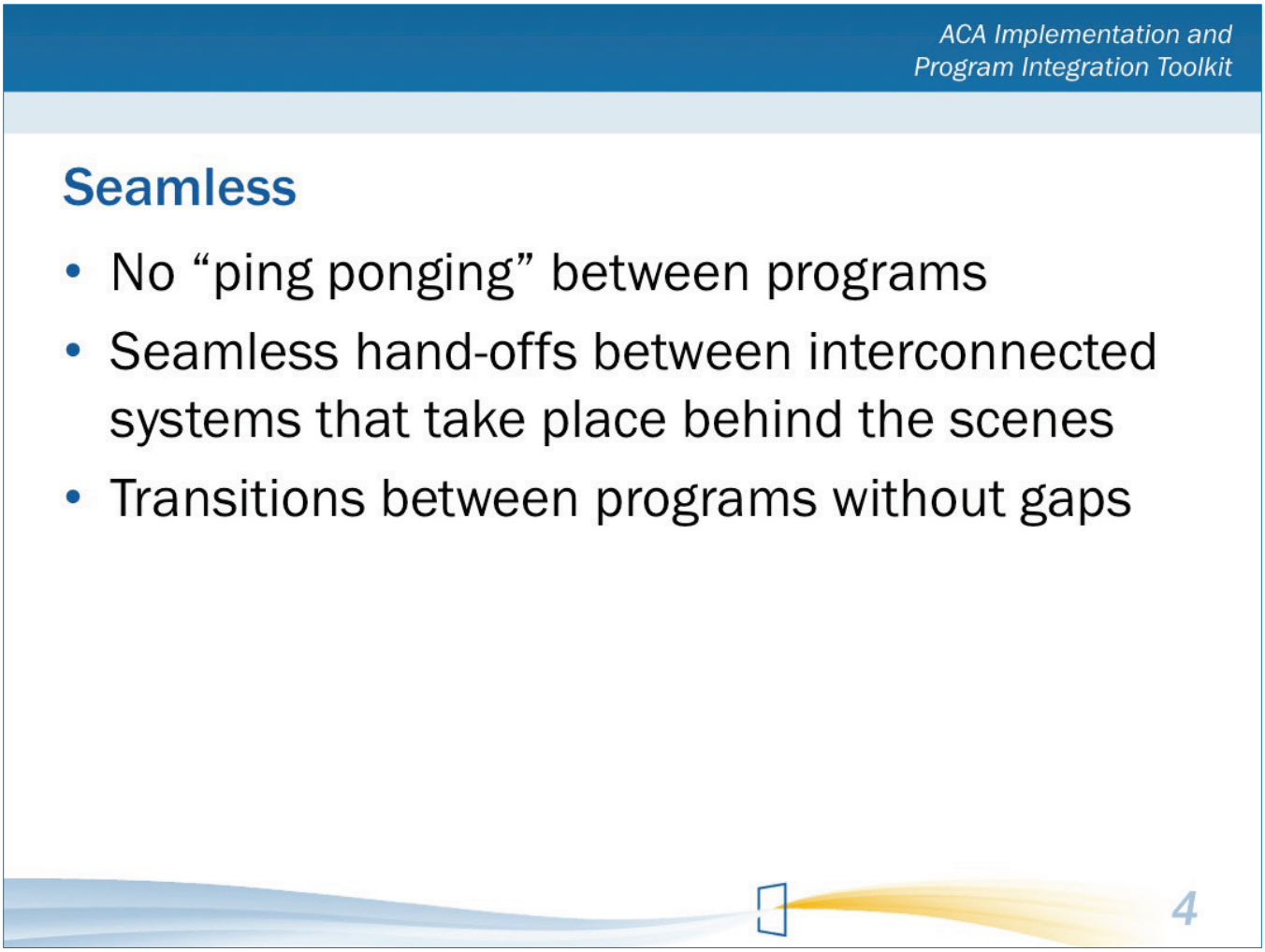
- Providing a "no wrong door" one-stop shopping experience rather than making consumers figure out where to seek specific health programs.
- Seamless process that ensures handoffs and sharing information occurs behind the scenes avoiding all gaps and potential stumbling blocks for consumers.
- Streamlined process that maximizes the use of technology and lessens reliance on paper.

Additionally, for a limited time only, enhanced federal matching dollars, covering between 90 and 100 percent of all costs, are available to fund IT investments that improve eligibility determinations for Medicaid. States can get a special waiver from normal cost-allocation rules so human services programs are not required to contribute to the cost of these investments.



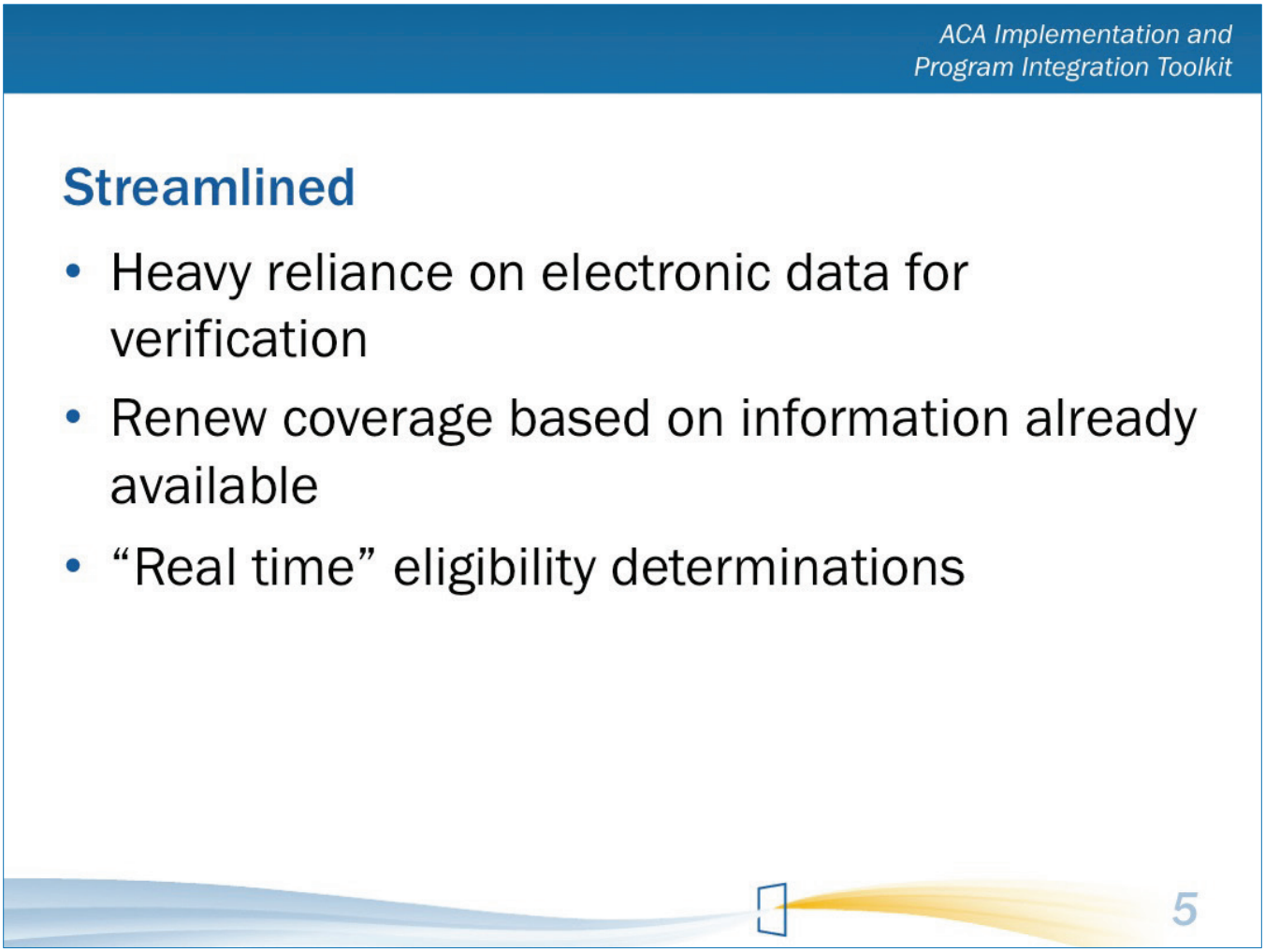
The ACA requires that states set up streamlined "no wrong door" access to all insurance affordability programs.

- This means that it doesn't matter where they apply – whether through the exchange, Medicaid, or CHIP agency – they will be assessed for eligibility for all those programs and they will be enrolled in the appropriate program. This is important because consumers will not likely know which program they will qualify for, and they won't have to.
- The single, streamlined application is key, in that it should give consumers the opportunity to only have to provide their information once.
- States are also required to set up processes that allow consumers to submit applications and renewals through the mail, in-person, telephone and online (further discussed in the Application and Renewal sections of this toolkit)



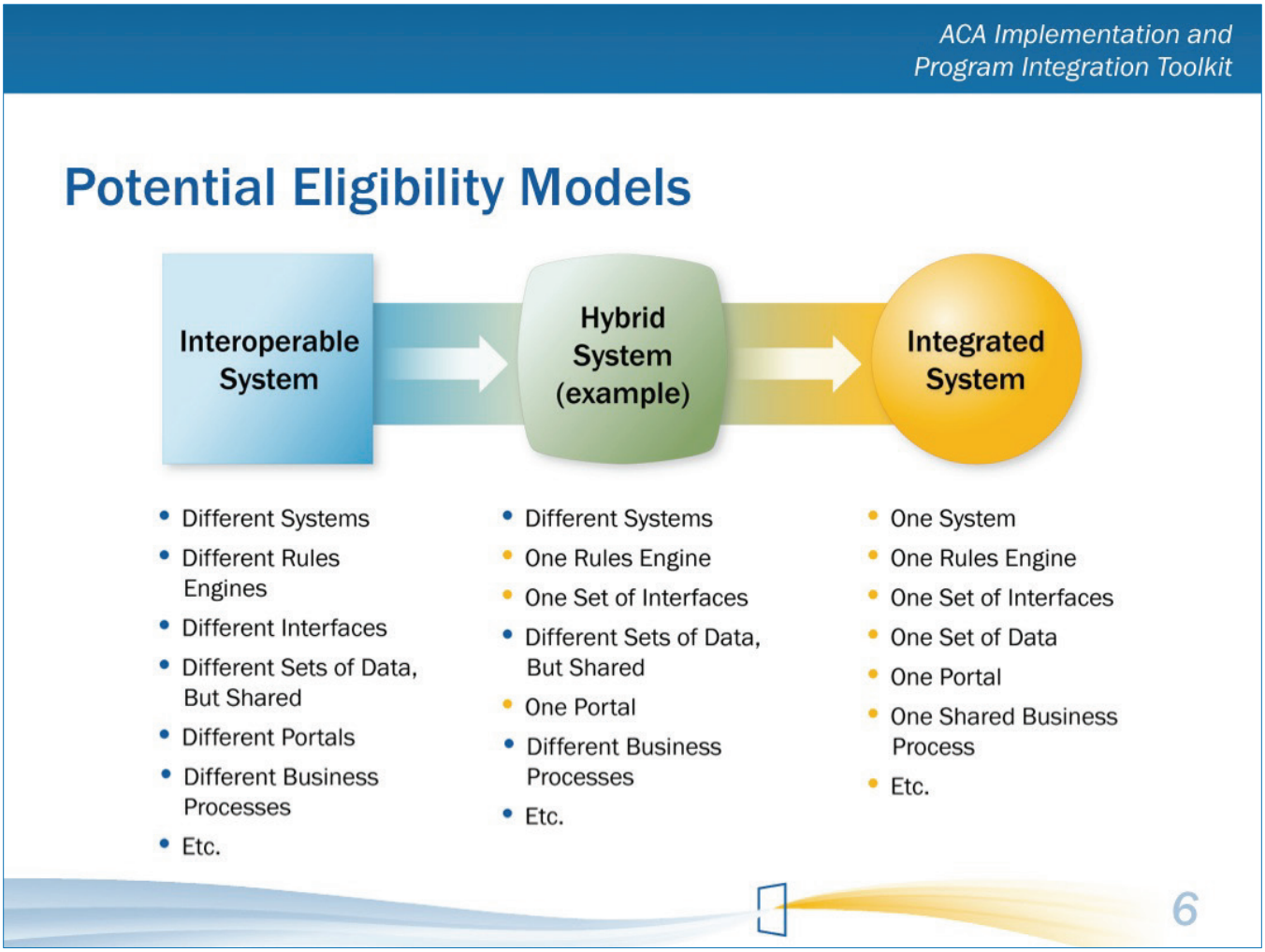
The process should be seamless.

- That means there should be no gaps but also no overlaps.
- If states have different entities determining eligibility for the different programs, handoffs accomplished electronically and behind the scenes. For example, people who apply at the Medicaid agency and are found by the Medicaid agency to likely be eligible for premium credits are not told to physically reapply to the exchange. Rather, their information is transferred to the exchange.
- In addition to the seamless transfer of information, once the exchange or Medicaid agency verifies an eligibility factor, the consumer will not be required to re-verify it., even if their case is transferred.
- There may be cases, however, when one door like the exchange does not complete the verification requirements in the same way Medicaid requires and in those cases, the consumer may have to have their information verified in another way. For example, if the exchange only uses tax information to verify income but Medicaid requires more recent information and uses quarterly wage information, then the person will have their more recent information verified.



The process also needs to be streamlined.

- There are high expectations for verification. As much as possible, states must use electronic data sources to verify information provided by consumers.
- The rules also allow for self-attestation of most eligibility factors (not citizenship and immigration status).
- Consumers can be asked to provide paper documentation only when information cannot be electronically verified, or when there is a conflict between the information provided by the consumer and information collected through data matching that would have an impact on eligibility.
- This kind of streamlined process also applies to renewals.
- Also, with the heavier reliance on technology and electronic data matches, there is a high expectation for eligibility determinations to be conducted in real time.



There are many ways that states can set up their eligibility systems and processes to accomplish the requirements around seamlessness. Potential models include:

- **Integrated:** Same entity processes eligibility across all programs.
- **Interoperable:** Separate entities process eligibility; consumer cases are transferred seamlessly through secure interfaces.
- **Hybrid:** There are shared services, such as a shared rules engine, between separate entities and information is transferred seamlessly between entities.

Applications

Background

Applications are the essential first step of a state's process to determine who is eligible for benefits and the amount of benefits they receive. Well-designed applications facilitate the enrollment process by enabling applicants to provide the information states need to make swift and accurate decisions.

Applications can also have a significant effect on which benefits low-income households obtain. Whether they elicit sufficient information to enable a state caseworker to screen applicants for a full package of benefits or enable applicants to indicate their desire for more help, applications set individuals on a path to obtaining one or more of the benefits for which they are eligible.

In recent years, in an attempt to simplify applications, many states created shorter, more focused applications that provide a pathway to individual programs, such as children's health coverage. This approach likely improves access to individual programs. But for the poorest families that are eligible for multiple benefit programs, this simplification has often made it harder to obtain a package of benefits — typically requiring that they complete multiple applications that solicit much of the same information. This has also resulted in states using more caseworker time to process multiple applications for the same families. Even more unfortunate, some families may miss out on benefits that could improve their well-being because they do not know they are eligible.

The Affordable Care Act's (ACA) changes in Medicaid eligibility rules will require states to revise, if not completely redesign, the applications they use to determine eligibility for health coverage. This includes health-only applications as well as multi-program applications. Changes include:

- **New requirements for health coverage application forms and processes.** The ACA requires states to use a single, streamlined application as a pathway to all health insurance affordability programs (Medicaid, CHIP, Basic Health if applicable, advance premium tax credits, and cost-sharing reductions). The goal of the single, streamlined application is to give individuals a single entry point to health coverage programs. States must also allow consumers to submit applications through the Internet, by telephone, by mail, and in person. And, states must permit the use of electronic and/or telephonic signatures as well as allow authorized representatives to help applicants with the application.

- **The development of an application that states can use for insurance affordability programs.** The U.S. Department of Health and Human Services (HHS) will be developing a single, streamlined application that states can use for Medicaid, CHIP, and premium tax credits. Alternatively, states can develop their own application that HHS must approve. To collect the information needed to complete eligibility determinations for people whose eligibility will be determined on a basis other than Modified Adjusted Gross Income, or MAGI (such as people with disabilities), states have the choice of using the HHS application, a state-developed alternative application along with a supplemental form, or a state-developed application designed specifically for this group.

The vision of enrollment and the role that the application will play in achieving that vision are even more important than the specific new application requirements. Millions of people will gain health coverage under the ACA. Rather than require these individuals to visit their local health and human services office to apply for coverage (although that may still be the most efficient option for millions, especially those applying for multiple programs), the ACA requires that the application for coverage be publicly available and largely a process that

individuals can manage on their own, without the help of a caseworker or trained assistor. This alone will necessitate a change in most states' forms.

While many states have designed very simple children's health coverage applications that many applicants fill out without assistance, many states continue to use application forms for Medicaid and other benefit programs that require some level of program knowledge or technical expertise that is often provided by an eligibility worker during an interview. Medicaid will be moving to a model where the application should be sufficient to determine eligibility and cannot require an interview. This model will require that the terms used, the flow of questions, how verification is sought, and the ease with which it is attached be navigable by the public. Of course, states must continue to assist individuals who want or need help in applying for health coverage. Nevertheless, creating an application form for health programs with relatively complex eligibility rules that the public can correctly complete on their own will likely require changes to states' applications.

As states consider the changes that they must make to their health and human services applications to connect individuals to health coverage under the ACA, they have a tremendous opportunity to create a pathway to other crucial benefits and work supports for the lowest-income individuals and families. Such an approach holds the promise of improving access for vulnerable families to benefits and programs that can help them as well as promoting more efficient use of state administrative resources. Virtually all non-seniors on Supplemental Nutrition Assistance Program (SNAP) will be eligible for Medicaid in 2014, and many households on Medicaid will be eligible for human services programs as well. In many cases, these programs seek and verify the same information from applicants. States can ill afford to duplicate staff efforts by having application processes that are disconnected from one another.

Community Organizations Will Play An Important Role Under the ACA

Community organizations and health care providers have long played an important role in helping to connect eligible individuals to Medicaid and CHIP, typically by providing informational materials about the program and/or by helping individuals to fill out applications and submit them with all required documentation to the state Medicaid agency. The ACA has given special prominence to community assistors through the creation of the Navigator program, which requires state exchanges to fund organizations to conduct outreach and provide assistance in the enrollment process for health subsidies. Including this group in your planning could be very useful.

Many states are not yet ready to design their new application forms or to assess the forthcoming HHS model form. Forms need to take into account the new eligibility rules, business processes, and computer systems that are not yet finalized. This is an appropriate time, however, for states to assess their current forms with respect to needed changes under the ACA. In addition, states can take stock of how well their current applications perform in order to leverage additional improvements:

- How useable and effective are today's forms for all users — applicants, application assistors, and eligibility workers?
- Is there a way to gather feedback on application forms from applicants and other users (particularly outside of the child health applications)?
- Do current forms, both multi-program and single program, create a pathway for vulnerable families to enroll in the full package of work supports? How successful are they in accomplishing multi-program enrollment?
- What changes would be needed to improve them — both to make them easier to use and to help connect poor families to a full range of benefits?

Beginning with a well-informed evaluation of the effectiveness of their current applications will better prepare states to begin designing their new approach to application forms.

Goals

This module will help states set guiding principles for making changes to their applications by:

- Taking an inventory of current application practices across key health and human services benefit programs and identifying what has worked and areas that need improvement.
- Identifying changes that need to be made to prepare for the ACA.
- Identifying optional changes that would help consumers and eligibility workers.
- Identifying what questions, if any, the state would need to add to a Medicaid application to make it an application for SNAP and/or other human services programs.
- Identifying how applications will affect other implementation decisions, including eligibility processes, IT, and staffing.

Tools

To help guide your discussions and decisions about how to change your application, this module includes the following tools:

1. **Exercise 1:** Take an inventory of all applications currently available for health coverage and other human services.
2. **Presentation:** Review application requirements under the ACA.
3. **Exercise 2:** Identify improvements that can be made to current applications.
4. **Exercise 3:** Key Opportunities for Integration! — Identify a strategy for developing Medicaid and SNAP and/or human services applications.
5. **Wrap-Up and Next Steps:** Identify guiding principles for the application process and issues that need to be taken into account during implementation planning.

How to Complete this Module

First, you will want to think about whom to involve in a workgroup focused on applications. Involving a diverse group of experts and stakeholders will ensure that you are considering all aspects of the work. You may want to consider including the following representatives:

- Medicaid, CHIP, SNAP, and other human services policy experts
- Representatives from the state's exchange organization
- Operational managers from field offices
- Representatives of eligibility staff and/or labor unions

- Data analysts familiar with your data file
- Representatives from customer support center
- State and/or vendor IT experts
- Representatives from a consumer groups that provide application assistance

You may also want to involve an outside facilitator if resources allow. At the end of this section, we suggest additional background materials you may want to distribute to the group.

Each of the exercises involves holding one or more workgroup meetings. Questions have been provided in each exercise to guide your conversations. As you work through discussion questions, make sure to take note of key decisions, unresolved issues that need further attention, and action steps that need to be taken to move forward with planning and implementation. We estimate you will need to schedule approximately eight hours of workgroup meetings to complete this module. You may choose to schedule them in a series of shorter meetings or as one all-day session.

Additionally, the first exercise requires that key workgroup members collect background information about current application practices and questions. An appropriate amount of time should be provided for these pre-workgroup meetings so the members come to the first meeting prepared to share the information gathered.

As always, you should feel free to modify the materials and exercises provided in this module to suit your state's specific needs and circumstances. Finally, you may find that information covered during this module to be helpful in making decisions related to the development of renewal forms and related processes.

Exercise 1

Gain a common understanding of current application processes and identify how they can be improved

We have all experienced the pain of completing a poorly designed form. Whether it was at the Department of Motor Vehicles or the doctor's office, questions that are vague or badly presented can leave us confused and frustrated. The goal of this exercise is to draw on your state's past experience in using applications to identify recommendations for the development of new consumer-centric applications.

Gathering Background Information

A good understanding of your current application process is a prerequisite to a conversation about how to create new and improved application processes. The first step in Exercise 1 will be to gather information about current application practices. In advance of your first workgroup session, each program area represented in your team (e.g., child, care, SNAP, Medicaid, exchange, etc.) should designate one representative to participate in a data collection group. This group should allow an appropriate amount of lead time, which will depend on your state's ability to quickly extract data from the relevant eligibility systems.

The data collection group can use Table 1 below to gather some basic information that will help your group identify the volume of applications currently processed by each program and which modes of application consumers use most frequently (use estimates, if precise data pulls are not possible given your timeframe). If possible, provide this information related to mode of application by type of application, e.g., health only vs. multi-benefit application.

Table 1. Current Application Volume and Mode

	Medicaid	CHIP	SNAP	Child Care Subsidies	TANF	Other
Average number of initial applications per month (over 12 months if possible)						
Share of applications by mode of application (online, paper, phone)	Mail:_____% Online:_____% Phone:_____% In-person:__%	Mail:_____ % Online:_____% Phone:_____% In-person:__%	Mail:_____% Online:____ % Phone:____ % In-person:_ %	Mail:_____% Online:_____% Phone:_____% In-person:__%	Mail:_____% Online:____% Phone:____ % In-person:__%	Mail:_____% Online:_____% Phone:_____% In-person:__%

Key workgroup members should also be assigned to reach out to their counterparts to collect information about experiences with current applications using the set of questions below. This can be gathered in a number of ways. For example, managers, eligibility workers and customer service representatives from each program area can gather information during staff meetings or they can hold small group meetings with a subset of eligibility workers, supervisors, and/or customer support representatives. Consumer groups can capture the information from other community groups during regularly planned stakeholder meetings or by distributing an

electronic survey to outreach and/or other organizations that provide application assistance. Workgroup members should be given adequate time to capture information using the following questions and should come prepared to share their findings during the first workgroup session. When gathering information, workgroup members may want to consider asking the questions separately for paper and online applications.

Questions on the Effectiveness of Current Applications

Key Questions: *Which questions are consistently not answered? Which questions are consistently answered incorrectly? What questions most often require caseworker explanations? Are these questions required to determine eligibility?*

Notes:

Key Question: *Which questions do consumers or application assisters often not understand, ask questions about, or complain about?*

Notes:

Key Questions: *If your program regularly has staff review information provided on applications when consumers complete an interview, consider the situation where most applications will not be reviewed in this way. How would questions need to be changed to ensure they are clearly soliciting the correct information?*

Notes:

Key Questions: *Does the application form follow the order of information required by the eligibility system? Is this an issue?*

Notes:

Key Questions: *How are consumers currently informed about verification requirements? Do applicants accurately follow directions about providing additional verification? (This can be for applications, renewals, or reported changes). Which aspects of verification present the most trouble?*

Notes:

Key Questions: *How do applications currently provide key consumer protections and notify them of their responsibilities? Do applicants appear to understand their rights and responsibilities? Do applicants ever express concern about the communication on applications?*

Notes:

Key Questions:

How are consumers currently informed about what happens once an application is submitted? Do they know: if they will they be contacted if the state needs additional information or how long it will take to find out if they are eligible for benefits?

Will they have to take additional steps like identifying a health care provider? What has worked best or not worked well in conveying this type of information?

Notes:

Key Questions:

What has your experience been with the length of applications? Are shorter applications better? Why or why not? Are longer applications that provide more information better? Why or why not?

Notes:

Key Questions:

If your program has an online application, what kinds of functionality (if any) have proven to be useful? Why?

If your program does not have an online application, what kinds of functionality do you think would be helpful? (Think about your own experiences in shopping, banking, and working online to think about what would be important functionality to include. Information about online application functionality can be found in Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement)

Notes:

Conducting Workgroup Meeting

After you complete the information-gathering portions of this exercise, you should schedule a workgroup meeting. This meeting will be a chance to reflect on the information collected about past experience. The questions below will help guide your discussion and make decisions about how to proceed with modifying and creating applications that are more consumer-centric while meeting eligibility workers' needs. We estimate it will take a total of approximately three hours to discuss all of the questions.

Discussion Questions on How to Improve Applications

Key Questions: *Which applications appear to be used most, and why? What can be learned from the most-used applications? Are there any applications the state wants to stop using or applications that can be consolidated or improved?*

Discussion:

Key Decisions:

Key Questions: *Are there data elements that you are currently collecting that are not used to make a determination? If so, can they be removed from the application? For programs that require an interview, are there data elements that can be collected during that process instead of the application? Which data elements (if any) fall into one of these categories?*

Discussion:

Key Decisions:

Key Question: *Which application questions have been troublesome? How can they be improved in the new applications? How can we get input on new questions (e.g., focus groups, in-depth interviews, meetings with stakeholders, etc.)?*

Discussion:

Key Decisions:

Presentation

Review application requirements under the ACA

The goal of the presentation is to clarify the ACA requirements related to applications. The presentation will share current application requirements and future requirements under the ACA. This presentation is intended to kick off the workgroup meeting for Exercise 2. It can also be used as background information for decision makers who are considering changes to your application. An outline of the presentation is below, and the full PowerPoint presentation can be found in Appendix 2.1.

- Consumers must be able to file applications by mail, in person, by telephone, online, and through other commonly used electronic formats.
- HHS will develop a single, streamlined application for states to use.
- States can develop an alternative application that is no more burdensome and receives HHS approval.
- States can use multi-benefit applications.
- For eligibility determinations not based on Modified Adjusted Gross Income (MAGI), states can use the HHS application, a state alternative application along with a supplemental form, or develop an application specifically for non-MAGI based Medicaid determinations.
- Information on applications must be provided in simple to understand, plain language and longstanding civil rights requirements pertaining to language access, accessibility for people with disabilities, and allowing non-applicants not to provide sensitive information remain.
- These requirements take effect January 1, 2014.

Exercise 2

Identify changes that need to be made to current applications to prepare for the ACA.

A workgroup meeting should be scheduled for Exercise 2. This meeting will start with a brief presentation on ACA requirements related to applications. The workgroup will then discuss the questions below and make decisions about how to proceed with preparing applications to meet the ACA application requirements. We estimate it will take a total of approximately two hours to discuss all of the questions.

Preparing for Applications for ACA Implementation Discussion Questions

Key Questions: *Are there required modes for Medicaid applications (in person, telephone, online, mail) that are currently not provided? Do other programs currently use any of the missing modes and if so, can that technology be leveraged for Medicaid? What application modes need to be created?*

Key Discussion Points:

Key Questions: *Does the state currently accept electronic and telephonic signatures? If not, what is needed to institute them?*

Key Discussion Points:

Key Questions: *What improvements will be needed to address accessibility and civil rights issues? In how many languages is the application available? Is the application accessible for people with disabilities (best answered by focus groups of people with different impairments)? Are non-applicants required to provide Social Security number and citizenship information?*

Key Discussion Points:

Key Question:	*Will the state use the HHS-developed application for all modes or develop alternative applications?*

Key Discussion Points:

Key Questions:	*If applicable, how will alternative applications be designed to meet the requirement to request only the information needed for eligibility determinations? For example, the online application can use logic-based questions that allow earlier questions to inform which subsequent questions are asked. How can this be accomplished on paper applications? Will phone and in-person applications use the online application question sequencing?*

Key Discussion Points:

Exercise 3

Key opportunity! Design an online multi-benefit application.

All states are required to allow consumers to file applications for Medicaid and other health subsidies online. Online applications can be designed to be dynamic — allowing for information provided by the consumer to determine which questions are later asked. For example, if an applicant indicated that he was male, the online application can be programmed to exclude any future questions related to pregnancy for that individual. The online applications can be designed to offer a pathway to SNAP and other benefit programs by allowing consumers to select which programs they would like to receive at the start of the application. Consumers then only need to be asked questions that are relevant to the benefits that they select. In this case applications can be programmed to screen in for other programs using the information provided, letting the application filer know if he/she appears eligible for other programs and giving him/her an opportunity to apply for those programs and answer any additional questions needed. In paper applications, questions can be sequenced, marked, or provided in sections so that consumers can easily choose to complete only the questions for programs for which they wish to apply.

Some state health agencies and advocates have been concerned that providing multi-benefit applications in lieu of health-only applications is too cumbersome for families and application assistors to navigate. This can be true if the state chooses to ask many questions that are not absolutely necessary at the time of application or if the questions are difficult to understand. The table in Appendix 2.3 lists data elements commonly requested for Medicaid and SNAP. This illustrates that the majority of data elements requested for one program are also needed for the other. Some data elements states currently request are not required for either program under federal rules and can be removed from applications altogether. Some information specific to SNAP can be collected during the interview process for SNAP. For example, a paper application may ask about student status but the interview can probe about specific student eligibility parameters. A similar exercise of identifying data elements from other programs such as child care subsidies and TANF are likely to yield similar results. To begin thinking through how to create unified applications across benefit programs that are less burdensome, your workgroup can use the discussion questions below.

Holding on To Vital Pathway to Benefits

Over 40 states currently accept Medicaid applications at human services offices. Typically, households that apply for health benefits there are also applying for other human services programs such as SNAP or child care. Those applications can maintain a path to health coverage no matter what the eligibility process for health coverage ultimately looks like.

Discussion Questions on Developing a Unified Online Application

Key Questions: *HHS will release data elements that will be used for determining eligibility for insurance affordability programs. If those have been released in time for your workgroup session, your group can determine if there are data elements that are currently collected by the state that do not have to be collected for Medicaid in 2014. Why are these questions asked? What are the consequences of dropping these questions from the application?*

Key Discussion Points:

Key Decisions:

Key Question: *What benefit programs make sense to include in a multi-benefit application that is built off of the Medicaid application?*

Key Discussion Points:

Key Decisions:

Key Questions: *What additional questions would need to be added for those programs? Or could applicants be screened for these other services during the interview?*

Key Discussion Points:

Decisions:

Key Question: *How can the combined health and SNAP application ensure that key SNAP consumer protections are reflected in the application design i.e. expedited screen, right to apply with name, address and signature, etc. (see appendix 2.4)*

Key Discussion Points:

Key Decisions:

Wrap-Up and Next Steps

Identify guiding principles for the application process and application issues that need to be taken into account during implementation planning

The goal of this section is for your workgroup to reflect on discussions and decisions made during Exercises 1-3 to develop guiding principles for the overall approach to applications and identify considerations for other implementation decisions including eligibility processes, IT considerations, and staffing.

Discussion Questions on Developing an Overall Approach to Applications

Key Questions: *What has worked best in applications and should be retained? What can be improved?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What guiding principles should we use in developing questions to ensure that they are easy to understand and answer?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What key functionalities such as "my account," logic-based questioning, etc., do we want to have in our online applications?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What will the strategy be for getting consumer input in the development of applications?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Questions: *Will we have multi-benefit applications? If so, which programs will be included, and what are design considerations?*

Key Decisions:

Decisions Pending:

Next Steps:

Resources

Regulations and Guidance

Medicaid Eligibility Final Rule 42 CFR Parts 431, 433, 435, and 457 "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010," U.S. Department of Health and Human Services, March 16, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

Exchange Eligibility Final Rule 45 CFR Parts 155, 156, and 157 "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," U.S. Department of Health and Human Services, March 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

Policy Papers on Creating Streamlined, User-Friendly Applications

Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage? by Julie Silas and Christina Tetreault, Consumers Union, November 2011, http://files.www.enrollamerica.org/best-practices-institute/publications-and-resources/2011/Public_Enrollment_Stations.pdf.

Health-e-App Public Access: A New Online Path to Children's Health Care Coverage in California: An Overview of the First Year, by Leslie Foster, Mathematica Policy Research, Inc., March 2012, http://www.mathematica-mpr.com/publications/pdfs/health/health_e_app_ib1.pdf.

Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at a Critical Moment, by Dottie Rosenbaum and Stacy Dean, Center on Budget and Policy Priorities, February 24, 2011, http://www.cbpp.org/cms/index.cfm?fa=view&id=3408.

Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement, by Shelby Gonzales and Samantha Artiga, Kaiser Commission on Medicaid and the Uninsured, June 2011, http://www.cbpp.org/files/6-27-11health.pdf.

Online Services for Key Low-Income Benefit Programs: What States Provide Online with Respect to SNAP, TANF, Child Care Assistance, Medicaid, CHIP, and General Assistance, Center on Budget and Policy Priorities, March 6, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=1414.

Streamlining and Coordinating Benefit Programs' Application Procedures, By Sharon Parrott, Donna Cohen Ross, and Liz Schott, Center on Budget and Policy Priorities, June 22, 2005, http://www.cbpp.org/files/6-22-05prosim.pdf.

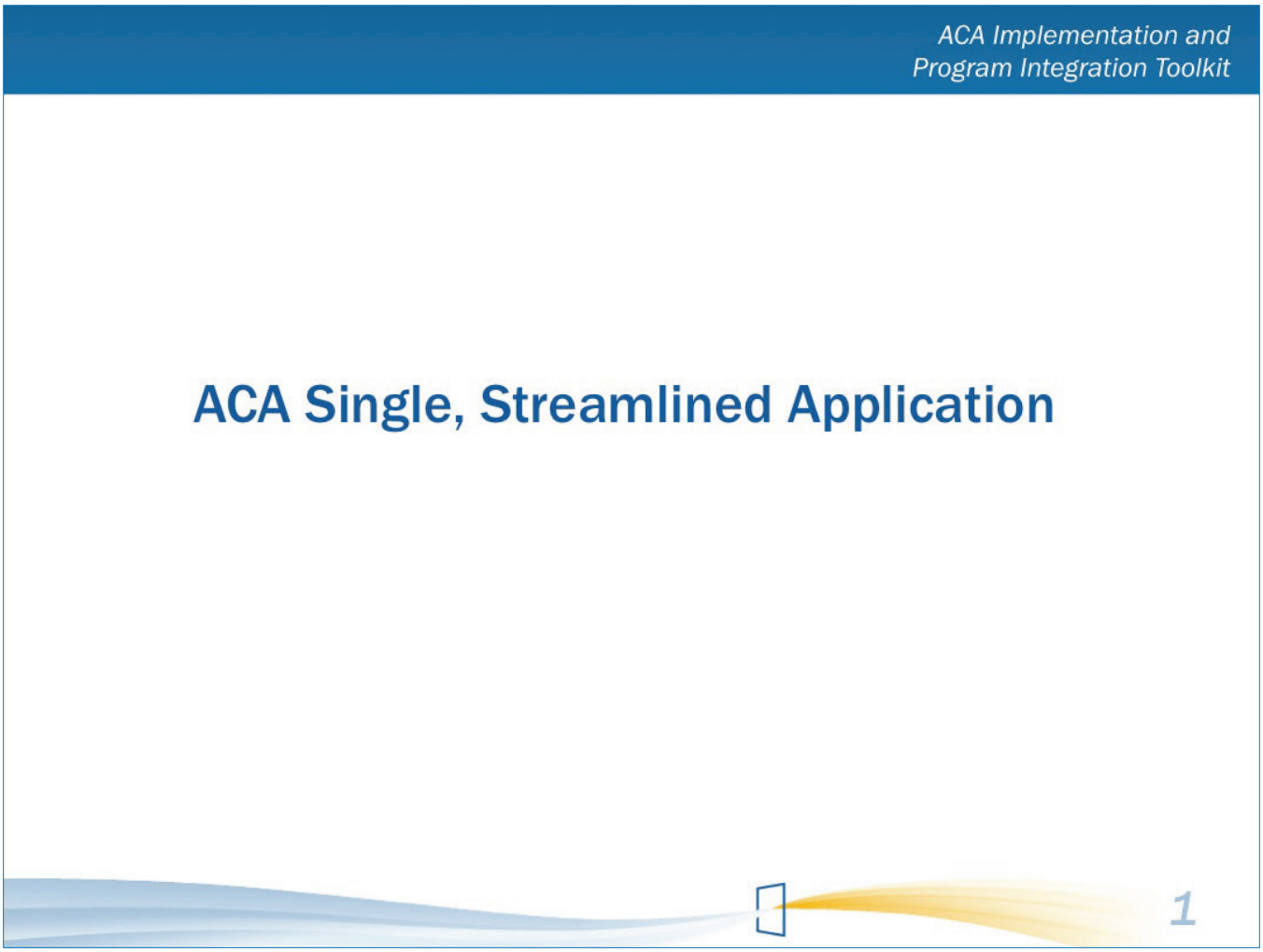
Using Online Tools to Improve Access to Assistance Programs: Effective Design and Outreach to Help People Get Work Supports via the Web, by Autumn Arnold, Workforce Central and Milwaukee Area Workforce Funding Alliance, Summer 2010, http://www.cfswc.org/page10005246.cfm.

Other Resources

User Experience 2014 Wireframes
Slides: *Building Blocks: The ABCs of Designing Enrollment Materials People Can Read*, by Joan Winchester, Nichole Donnelly, Eva Anderson, and Mercedes Blanco, Maximus Center for Health Literacy, December 13, 2011, http://www.enrollamerica.org/best-practices-institute/webinar-archives/building-blocks-the-abcs-of-designing-enrollment-materials-people-can-read.

Communicating in Plain Language, by Nicole Donnelly, Penny Lane, and Joan Winchester at the Maximus Center for Health Literacy, February 2012, http://files.www.enrollamerica.org/best-practices-institute/publications-and-resources/2012/Communicating_with_Plain_Language.pdf.

Appendix 2.1: PowerPoint Presentation on ACA Application Requirements



No wrong door:

- Key to the vision of providing a "no wrong door," states must have a single, streamlined application that provides access to all insurance affordability programs, including Medicaid, CHIP, premium tax credits and cost-sharing subsidies and Basic Health (if applicable).
- Applicants will not have to know what they qualify for and what to apply for. Rather, they can fill out one application and regardless of where they submit it, the correct determination should be made without requiring additional forms to be completed.

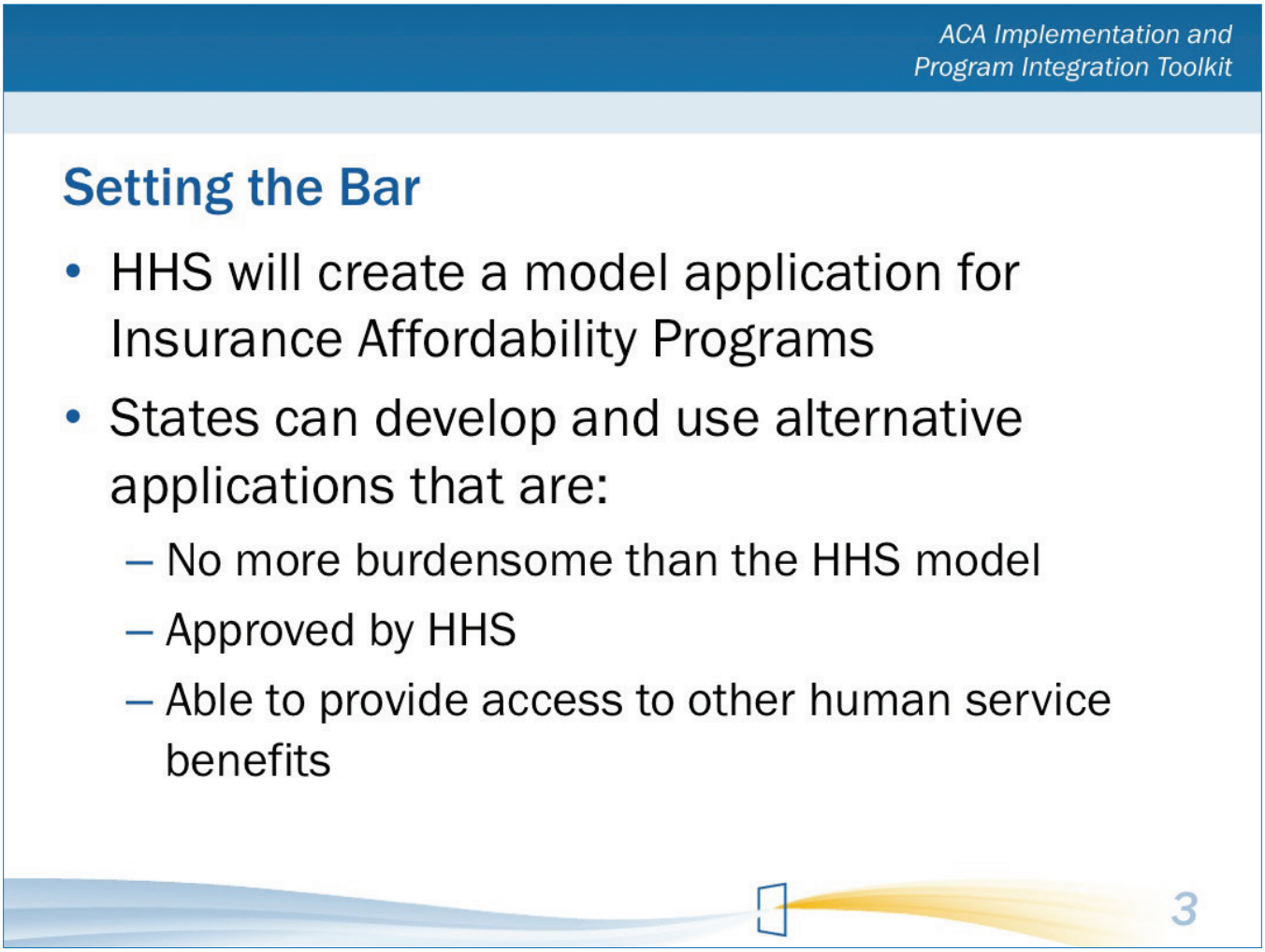
Modes for submitting applications and supporting documentation:

- States must allow for the single, streamlined application to be filed online, in person, over the phone, by mail and other commonly used electronic formats (including fax).
- Consumers must also be able to provide documentation needed for eligibility through each of these formats and states must accept electronic and telephonic signatures.

Applications must adhere to long-standing civil rights requirements including:

- Applications must be provided in a manner that is accessible to persons with limited English proficiency (at no cost to the consumer).
- Application must provide auxiliary aids and services at no cost to the consumer in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

- Applications must provide a pathway to benefits to eligible individuals who are in mixed citizenship/immigration status households. Protections include not asking non-applicants to disclose their citizenship/immigration status.
- There are also limitations on request of social security numbers including not requiring them of non-applicants, and providing appropriate notices when making optional requests.
- The applications should be written in plain language that is easy to understand.

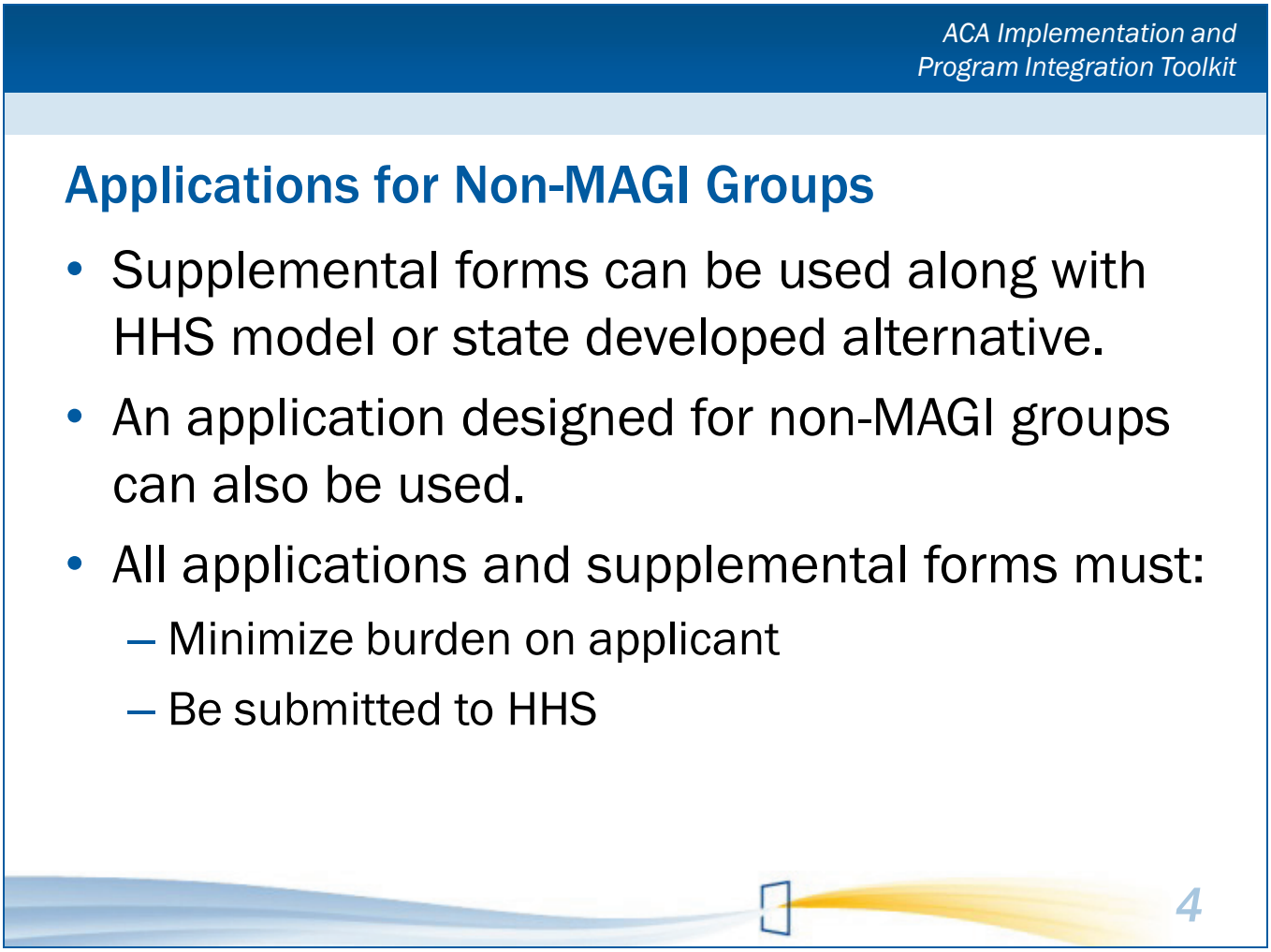


HHS application:

- HHS will develop a model application that states can opt to use.

State alternative applications:

- States can develop alternative applications, but they must not be more burdensome than the HHS developed application and must be approved by HHS initially and anytime substantive changes are made.
- States can develop an alternative application that also provides a pathway to other human service benefit programs but they must also be approved by HHS and they can't replace the single, streamlined application that is only for insurance affordability programs.



To collect information needed to complete eligibility determinations for those who are eligible for Medicaid on a basis other than MAGI, states have two options:

- They can use the HHS or state developed single, streamlined application along with supplemental forms, or
- They can use a form designed specifically for non-MAGI groups.
- In both cases, the application or supplemental forms must minimize the burden on consumers; and
- They must be submitted to HHS but the state does not have to get HHS approval for using these forms (however, the forms must be available for review by the public).

Appendix 2.2: Requirements for Key Application Components in SNAP and Medicaid

	SNAP	Current Medicaid	Future Medicaid Using MAGI Methodology
Application Filing Method	Paper application is required. States have the option to allow for applications to be submitted online or by phone.	Paper application is required. States have the option to use other filing formats, including online and telephone. Many states have opted to provide online applications and some also allow telephone applications.	Applicants must be allowed to file online, in person, or by mail or telephone
Signature	A responsible household member or authorized representative must sign the application under penalty of perjury, with notice of this provided. Electronic signatures and telephonic signatures (at state option) are acceptable.	The application filer or authorized representative must sign the application under penalty of perjury. In guidance, the Centers for Medicare and Medicaid Services has reassured states that electronic signatures are acceptable. Exception: No signature is required under Express Lane Eligibility.	The application filer or authorized representative must sign the application under penalty of perjury (tax payers receiving Advance Premium Tax Credits must make an attestation that they are aware of key rule associated with the credit). Electronic signatures and telephonic signatures must be accepted.
General	• If a state has a multi-program application, applicants must be able to apply for SNAP by answering only the SNAP questions. • States must allow applicants to initiate the application and set a filing date by just providing name, address and signature. • States must screen for expedited eligibility on or near the front page of the application (once a form becomes a SNAP application).	• States must offer an application pathway for pregnant women, infants, and children outside of the TANF application. • States have the flexibility to provide applications for specific categories of eligibility, a Medicaid-only application, or multi-benefit applications that clearly identify Medicaid-only sections.	• States must use either the single, streamlined application developed by HHS or an alternative single, streamlined application developed by the state and approved by HHS. • Alternative applications must be no more burdensome than the application developed by HHS.
Interview	An interview is required at application and no less than every 12 or 24 months thereafter (depending on the type of household) but can be conducted over the telephone.	States have the option to require interviews. Only one state requires a face-to-face interview for children's Medicaid, and seven states require it for parents.	States cannot require face-to-face interviews and must have processes in place to provide assistance during interviews if needed.
Accessibility under Civil Rights Laws	Civil rights laws apply to applications. Ensuring access for individuals with limited English proficiency, disabilities, and those who live with household members who are reluctant to provide information about their citizenship status or Social Security numbers remains an important legal requirement for state applications and application processes.		

Appendix 2.3: Items Commonly Asked for in the Completion of the Application Process

We have included a list of items that are commonly requested in benefit applications and identified whether or not the information is required to be collected during the application process. This is not a legal analysis of each required date element for each program. Instead, it is meant to illustrate how much information is common to both programs.

It is important to note that not all questions asked on applications are required to be answered by applicants, for example programs must request information about race/ethnicity but they can't require applicants to answer that question. States frequently ask for information that can help their process such as applicants' telephone numbers and e-mail addresses even though providing that information is not required to determine eligibility. Additionally, not all information that is required to be collected during the application process must be collected on the application. For example, SNAP applicants can submit an application and protect the date of the application by only providing a name, address and signature. The remaining data can be collected at another point in the application process such as the interview. States frequently leave more obscure questions or follow up inquiries for the interview rather than include every aspect of SNAP eligibility on the application form.

Your state can add to the items in the table if there are other questions that you ask on your applications that are not listed here (it's important to consider why those questions are asked and if they are needed). Use the table below to identify and discuss your findings:

Items Commonly requested on applications*	For whom is the item requested?	Currently required or necessary to determine coverage category for Medicaid	Required for or necessary to determine benefit levels or special status under SNAP
1. Names of all household members applying for benefits	Applicant Only	Yes	Yes
2. Date of Birth	Applicant Only	Yes	Yes
3. Place of birth	Applicant Only	No	No
4. Gender	Applicant Only	No	No
5. Race / Ethnicity	Applicant Only	Yes	Yes
6. US citizenship	Applicant Only	Yes	Yes
7. SSN	Applicant Only	Yes	Yes
8. Preferred managed care plan	Applicant Only	No	No
9. Other Health Insurance	Applicant Only	Yes	No
10. Names of other household members	Household	Yes	Yes
11. Relationships of all household members (including those not	Household	Yes	Yes

Items Commonly requested on applications*	For whom is the item requested?	Currently required or necessary to determine coverage category for Medicaid	Required for or necessary to determine benefit levels or special status under SNAP
applying for benefits)			
12. Pregnant	Household	Yes	Yes – only for certain Able-Bodied Adults Without Dependents
13. Income	Household	Yes	Yes
14. Self-Employment status	Household	Yes	Yes
15. Student status	Household	Yes	Yes
16. Medical expenses	Household	Yes	Yes
17. Other expenses (such as child care and housing costs)	Household	State option	Yes
18. Assets	Household	State option	State option
19. Name of primary applicant	Household	Yes	Yes
20. Address	Household	Yes	Yes
21. Phone Number	Household	No	No
22. Email address	Household	No	No
23. Preferred method to be contacted	Household	No	No
24. Authorized representative	Household	Yes	Yes
25. Disability status	Individual	Yes	Yes
26. Migrant or seasonal farm worker	Household	No	Yes
27. Pays child support	Household	Yes	Yes

**This listing does not include every element of eligibility in Medicaid or SNAP.*

Appendix 2.4 Federal SNAP Application Requirements

SNAP and Medicaid share many similar applications requirements. Some are meant to protect consumers by informing them how information will be used, shared and verified. Other requirements ensure that applications do not discriminate and are accessible to those with disabilities or limited English proficiency. Both programs also require that applications be signed under penalty of perjury and allow for authorized representatives.

There are a few application requirements that are specific to SNAP, such as including questions early in the application that screen individuals to see if they are eligible to receive expedited benefits and the right to file an incomplete application with as little as a name address and signature. States wishing to create an application for health and SNAP will need to decide how to adapt applications to meet these requirements.

Expedited Service Screen

Destitute households are eligible for "expedited service" (which means they will receive their benefits within seven days) if they have less than $150 in monthly income and less than $100 in cash on hand and other liquid resources, if their combined monthly income and liquid resources exceed their shelter expenses, or if they are migrant or seasonal farmworkers with less than $100 in resources.

SNAP rules require a description of SNAP expedited service provisions on or near the front of the application and a process that ensures the screening occurs promptly. For example: The Georgia application asks the following questions:

Do I Qualify to Get Food Stamps Faster?

Answer these questions about yourself and all household members to see if you can get Food Stamps within 7 days.

1. Are you or any household member a migrant or seasonal farm worker? q Yes q No
2. How much money will you and all household members get this month? $_____
3. How much money do you and all household members have in cash or in the bank? $ _____
4. How much do you and all household members pay for rent or mortgage? $_____
5. How much do you and all household members pay for electric, water, gas, etc.? $_____

Ability to File an Incomplete Application

SNAP rules require the application notify the household that it may immediately file an incomplete application to establish a filing date, as long as it contains the applicants name, address, and signature. These items must be on or near the first page of the application and the application process must allow for processing an incomplete application. The requirement applies throughout the application. Households must be able to file an incomplete application at anytime. Missing information can be collected during the household's interview.

The requirement protects the filing date and ensures the household is able to answer truthfully if he or she does not understand the question.

Other SNAP Requirements

- Notice that benefits are provided from the date of application.
- List of specific items household must provide documentation of. (This does not have to be on the application form, but be provided to applicants.)
- Description of the civil and criminal provisions and penalties for violations of SNAP rules.
- For multi-program applications language that makes clear that the applicant only has to answer questions that are relevant for the program(s) he or she is seeking.

Verifications

Background

Verification of consumer statements about their income and other circumstances is a required component of Medicaid and other public benefit programs' eligibility processes. This is intended to ensure program integrity and improve the accuracy of eligibility and benefit decisions. In practice, however, verification often places a significant burden on eligible consumers who may have difficulty securing the required documents, such as paystubs or birth certificates. When the verification requirements are particularly onerous, they often cause delays in receiving benefits, and in some cases they prevent eligible individuals from gaining access to benefits at all.

For consumers who apply for multiple benefits, having separate verification processes for each benefit program can be burdensome as consumers are often asked to provide documentation multiple times to verify the same eligibility factor. Consider a family making multiple paystubs and sending them to separate state agencies at different times of the year in order to qualify for a package of benefits. This lack of program coordination also results in inefficiencies as multiple caseworkers spend time verifying the same information for the same consumers. Different caseworkers end up scanning the same document, or calling an employer to verify income multiple times.

Health reform's vision for a streamlined eligibility and renewal process moves away from burdensome documentation requirements. To support real-time eligibility determinations, the health reform law requires states to expand the use of electronic verification sources and rely less on paper documentation. When a family applies for health care coverage in 2014, Medicaid and the exchange must first verify applicants' information with the federal hub, which will include data from the Social Security Administration, Department of Homeland Security, and the Internal Revenue Service, and then tap into other state data sources. Medicaid and the exchange can ask for documentation only if they are unable to verify eligibility factors through these sources or the information provided by the applicant and electronic sources are not compatible with statements made by the consumer.

The changes required by the Affordable Care Act (ACA) offer states an exciting opportunity to modernize their programs and improve efficiency. Using electronically available data can streamline the enrollment and renewal processes, thereby reducing the amount of time and resources that workers spend tracking down and processing documentation, and help more people keep their coverage. In addition, for a limited time, the federal government will provide an enhanced match for Medicaid eligibility system upgrades that also benefit human services programs.

As states think through how to meet the health program verification requirements in 2014, now is a good time to assess opportunities to integrate policies and processes across programs. As mentioned previously, most low-income families are eligible for more than one program. States can make it easier for these families to obtain benefits by allowing information verified in one program to determine or update eligibility for another program. Sharing verification in this way reduces the number of times a family must provide the same documentation to various agencies or caseworkers. For example, families without health problems may be more likely to inform their SNAP (Supplemental Nutrition Assistance Program) or child care caseworker about changes in their circumstances (such as a new address) because those are the benefits they need on a daily basis. Rather than require families to provide this information to Medicaid as well, the state can allow Medicaid caseworkers to simply check other programs for the most recent information. Such efforts to share information

and streamline verification policies and processes across programs will reduce the burden on families and caseworkers, and help ensure that low-income families get the supports they need.

Goals

This module will help states:

- Learn the new verification requirements under the ACA.
- Conduct a review of the state's current practices for verifying information.
- Evaluate databases for use in verifying eligibility.
- Plan how to redesign verification policies and processes for 2014.

Tools

To help guide your discussions and decisions about how to set up your system for verifying information, this module includes the following activities:

1. **Presentation:** Review verification requirements under the ACA.
2. **Exercise 1:** Conduct a scan of current state verification policies, processes, and data sources.
3. **Exercise 2:** Identify improvements that can be made to the verification process.
4. **Wrap-Up and Next Steps:** Determine policies and processes for verifying information in 2014.

How to Complete this Module

As a first step, you will want to think about who you involve in a workgroup focused on your verification processes. To complete this section, you will need involvement from staff most familiar with the verification policies in your state's health and human services programs. Involving a diverse group of experts and stakeholders will ensure that your group discussions are considering all aspects of the work, so you may want to consider including the following representatives:

- Medicaid, the Children's Health Insurance Program (CHIP), and SNAP policy experts
- Operational managers from field offices
- Field supervisors (to weigh in on the policies and how they affect field operations)
- Representatives of eligibility staff and/or labor unions
- Quality assurance representatives
- Data analysts familiar with your data file
- State and/or vendor IT experts

You may also want to bring in an outside facilitator if resources allow. At the end of this section we suggest additional background materials you may want to distribute to the group.

Some of the exercises involve gathering background information that will help inform your decision making, while others involve holding workgroup meetings. We have provided tools and resources that you can use to gather and analyze information about your current processes, as well as questions to guide your conversations. You should, however, feel free to modify these tools as you see fit. As you work through discussion questions, make sure to take note of key decisions, unresolved issues that need further attention, and action steps that need to be taken to move forward with planning and implementation.

We estimate you will need to schedule approximately four hours of workgroup meetings to complete this section. You may choose to schedule them in a series of shorter meetings or as a one-day session, depending on your convenience.

Finally, you should feel free to customize and add to the exercises and materials provided in this module if that will be useful and better serve your state's needs.

Presentation

Review verification requirements under the ACA

We recommend that you begin with a presentation to provide the workgroup with an overview of the new Medicaid verification requirements that will be in effect in 2014. It is included in this module primarily as an education piece, but will also be useful in setting the stage for your discussions on how you may want to design a new verification process for your state. If workgroup participants are already highly familiar with the new requirements, you may choose to skip the presentation.

The focus of the presentation is the overall vision for a streamlined process that relies primarily on electronic verification and makes the key points below. Template PowerPoint presentation slides can be found in Appendix 3.1.

- The ACA envisions a data-driven verification system. Medicaid and exchange rules require the use of electronic data and applicant/enrollee attestation in verifying eligibility information at enrollment and renewal to enable real-time processing of applications for qualified health plans (QHPs) and for insurance affordability programs.
- States will have access to a federal hub which at a minimum will contain data from the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service.
- States will also be required to use other state data sources and with HHS approval can use alternative sources as long their use reduces administrative burdens on individuals while maintaining accuracy, confidentiality, coordination and minimizing delay.
- Documentation may be requested from the applicant only if the exchange or the Medicaid agency is unable to verify through these sources. If the attestation provided by the individual is "reasonably compatible" with the electronic data or other information that the exchange or Medicaid agency has obtained from other sources, no further information may be requested of the applicant filer.
- "Reasonably compatible" does not mean that the information is identical, but rather generally consistent. For verifying income, income obtained through an electronic data match is reasonably compatible with income provided by or on behalf of an individual if both are above or below the applicable income standard or other relevant income threshold.
- States must develop a verification plan that must be made available to the Secretary of the U.S. Department of Health and Human Services (HHS) upon request. The plan must describe the Medicaid agency's verification policies and procedures, including the standards applied by the state in determining the usefulness of financial information obtained through required data matching.
- State exchanges may use processes to obtain and verify individual eligibility information other than those outlined in the proposed rules, provided that modifications reduce administrative burdens on individuals while maintaining accuracy, confidentiality, and coordination and minimizing delay, and further provided that the Secretary approves the alternative process.

Exercise 1

Review state verification policies, processes, and data sources

Before your workgroup embarks on the task of designing what your verification processes for 2014 will be, all members should understand how verification is currently done in Medicaid, SNAP, and the other human services programs you want to streamline. Conducting background research and a review of your state's verification policies, processes, and data sources will be helpful prior to holding your first workgroup meeting. This exercise provides the tools to conduct that review, and will help you analyze the strengths and weaknesses of your current verification processes. Depending on how accessible the data are to your group, allow yourself and your team an appropriate amount of lead time for this task. We recommend having the workgroup members responsible for this assignment present their findings at the first workgroup meeting.

For the first task, ask members of your workgroup who are experts in the relevant programs to answer the questions presented in Table 1 with respect to their program. To do this, they will need access to your state's current verification rules and procedures for Medicaid, CHIP, SNAP, and other applicable programs. It would also be helpful to have copies of any applicable forms currently used to collect documentation from clients, such as landlord statements or employment forms. If you have electronic documents that are indexed by type, you might consider pulling data from your electronic document management system on the most common types of paper verification being submitted by clients. Referencing recent Medicaid Payment Error Rate Measurement (PERM) SNAP Quality Control (QC) data on errors related to verification — especially income — might also be helpful for the workgroup as background information.

Table 1. Description of State Verification Processes

	Medicaid	CHIP	SNAP	Other
What eligibility factors are routinely verified to determine eligibility (e.g., income, household composition, citizenship, etc.)?				
What methods (e.g., administrative, paper documents, self-attestation) are used to verify non-income information?				
What methods (e.g., administrative, paper documents, self-attestation) are used to verify income information?				
What methods (e.g., administrative, paper documents, self-attestation) are used to verify resource-related information?				

	Medicaid	CHIP	SNAP	Other
How do verification methods vary for initial eligibility, renewal, and periodic checks?				
How are discrepancies addressed when information from different verification sources are not consistent?				

The next step is to take an inventory of the current databases your state uses to electronically verify information in Medicaid, CHIP, SNAP, and other programs. To conduct this inventory, it will be helpful to have descriptions of your current electronic verification sources, including interfaces with the eligibility system, contracted services like The Work Number from the TALX Corporation, or a gopher system that taps into several data sources at once, if you have one.

Working with program staff who are familiar with the electronic data sources currently used in your state, complete Table 2. List the various databases used, and for each data source, indicate which data elements can be verified through the database; how accurate and reliable is the information contained; how extensively the database is used now; and the process for conducting the electronic verification.

Table 2. Description of Capabilities of Current Sources of Electronic Verification

List of databases	What programs use this data source to verify information?	What required data elements can be verified?	How accurate and reliable is the information in the database? How timely is the information?	For what percent of cases can information be verified using this database?	Is the verification real-time vs. batch? Does information in the database require caseworker reviews?	Can this database be used to verify Medicaid eligibility in 2014? If so, what modifications would need to be made?
Ex. Work Number						
Ex. State Wage Reporting System						
Ex. SSA						

Exercise 2

Identify improvements that can be made to current verification processes

After completing the tasks in Exercise 1, the next step is to schedule a two-hour workgroup meeting to consider the information you have gathered and discuss your state's current verification processes — how well does the current process work and how can it be improved? Make sure that all your workgroup members have copies of the tables that were completed in Exercise 1, along with all the other supporting materials, such as copies of verification policies and procedures, verification forms, and descriptions of electronic data sources used for verification.

To help guide your discussions, we have provided a series of questions below. These questions are intended to help you assess your verification processes and identify gaps that you might want to consider addressing. Some of these questions are also designed to help you think through how well your current process fits the ACA's vision for how verification should be conducted in 2014. As you go through these questions, try to identify any commonalities across programs. This will help you to identify issues that are systemic and perhaps need to be prioritized.

Discussion Questions on Verification Process

Key Questions: *What pieces of information is your state verifying that are not required by federal law? (See Appendix 3.2 for detail on federal verification requirements in Medicaid and SNAP.) What would the implications be of removing these items from the list of factors that the state verifies?*

Key Discussion Points:

Key Questions: *In general, how difficult is it for your state to verify the required components of eligibility? How long does verification take? Which factors do clients have the most difficulty verifying?*

Key Discussion Points:

Key Questions: *How frequently are applications pended because of a lack of verification? How frequently are applications denied because of a lack of verification?*

Key Discussion Points:

Key Questions: *Could your state benefit from less burdensome methods of verification that aren't being used? What would it take to implement these verification methods?*

Key Discussion Points:

Key Questions: *Are data being shared across programs? If so, which programs share data? Are there other opportunities for data sharing that your state could take advantage of?*

Key Discussion Points:

Key Questions: *Which databases that are used now will be useful for verifying eligibility in 2014? How would these databases need to be modified in order to meet the ACA's requirements or to implement ACA options under serious consideration in your state?*

Key Discussion Points:

Key Questions: *Are there other databases not currently used by the state that could be useful for verifying eligibility in 2014? (Appendix 3.3 provides a summary of many of the federal, state, and commercial data sources that are available.) What is the cost of using these databases for verification? What is the effort involved in verifying information through these databases?*

Key Discussion Points:

Key Questions: *Does your current process meet the requirements for verifying Medicaid eligibility in 2014? What changes do you need to make to your process to meet the ACA requirements or take advantage of options permitted by the ACA? How will these changes affect how you conduct verifications for other programs?*

Key Discussion Points:

Key Question: *Are there simplifications or data matches required or permitted under the ACA that can also be applied to other programs?*

Key Discussion Points:

Wrap-Up and Next Steps

Determine policies and processes for verifying information in 2014

At this stage, you will have a good sense of how your verification processes work, what sources of data are available to your state, when the state chooses to verify more than what is federally required, and what gaps need to be addressed to begin redesigning your verification system for 2014. The final step is for you to start thinking about how your state will establish policies for verification. While there are a number of federal requirements under the ACA, there is also quite a bit of state flexibility. Some policies — and the specifics of how they will be implemented — will be decided at the state level.

The next step is to convene your workgroup of key staff and stakeholders to decide on these policies. The discussion questions below outline some of the key issues that will need to be addressed as you develop your new policies and process and will help guide your discussion. Be sure to note any key decisions made, identify issues that need further discussion, and identify next steps that will be needed to move your process along and to start putting together your verification plan.

For this meeting, it will be important to involve quality assurance and IT systems staff familiar with your current electronic verification interfaces, in addition to your verification workgroup. Plan for a two-hour meeting to explore the questions below.

Discussion Questions on Verification Policies

Key Questions: *What data sources will the state connect to?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Questions: *What other forms of verification will the state accept in 2014? For which eligibility factors will the state consider self-attestation as a form of verification? What forms of paper documentation will be considered acceptable?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *How will the state define reasonable compatibility? Under what circumstances will consumers be asked to provide documentation?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Questions: *What business rules will apply when information obtained through electronic sources is inconsistent (e.g., federal hub for IRS data first, if it is reasonably compatible, no further verification required, if not, then check quarterly wages next, etc.)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What is the hierarchy of data sources when the information is inconsistent (e.g., which verification trumps the other: quarterly wages trumps IRS, etc.)?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What processes will the state put in place to give families an opportunity to challenge and correct information that the state has obtained through data matches?*

Key Decisions:

Decisions Pending:

Next Steps:

Resources

Regulations and Guidance

Medicaid Eligibility Final Rule 42 CFR Parts 431, 433, 435, and 457 "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010," U.S. Department of Health and Human Services, March 16, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

Exchange Eligibility Final Rule 45 CFR Parts 155, 156, and 157 "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," U.S. Department of Health and Human Services, March 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

SNAP Verification Requirements and State Options, U.S. Department of Agriculture, July 10, 2009, http://www.fns.usda.gov/snap/rules/Memo/2009/verification-requirements.pdf.

Information on Electronic Verification Sources

Memo for New York State Exchange Team on Income Verification Product Evaluation, Manatt Health Solutions, October 2011, http://www.statereforum.org/shinebrowse/documents/all?sort=desc&order=date&state=278.

New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States, by Donna Cohen Ross, Center on Budget and Policy Priorities, April 20, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3159.

Policy Papers on Streamlining and Simplifying Verification Processes

Easing Benefit Enrollment and Retention by Reducing the Burden of Providing Verification, by Liz Schott and Sharon Parrott, Center on Budget and Policy Priorities, December 13, 2005, http://www.cbpp.org/files/12-13-05prosim.pdf.

Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at a Critical Moment, by Dottie Rosenbaum and Stacy Dean, Center on Budget and Policy Priorities, February 24, 2011, http://www.cbpp.org/cms/index.cfm?fa=view&id=3408.

Lessons from States with Self-Declaration of Income Policies, by Danielle Holahan and Elise Hubert, United Hospital Fund, September 2, 2004, http://www.uhfnyc.org/publications/237565.

Program Design Snapshot: Paperless Income Verification, by Joe Touschner, Georgetown University Health Policy Institute Center for Children and Families, March 2009, http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/income%20verification%20final.pdf.

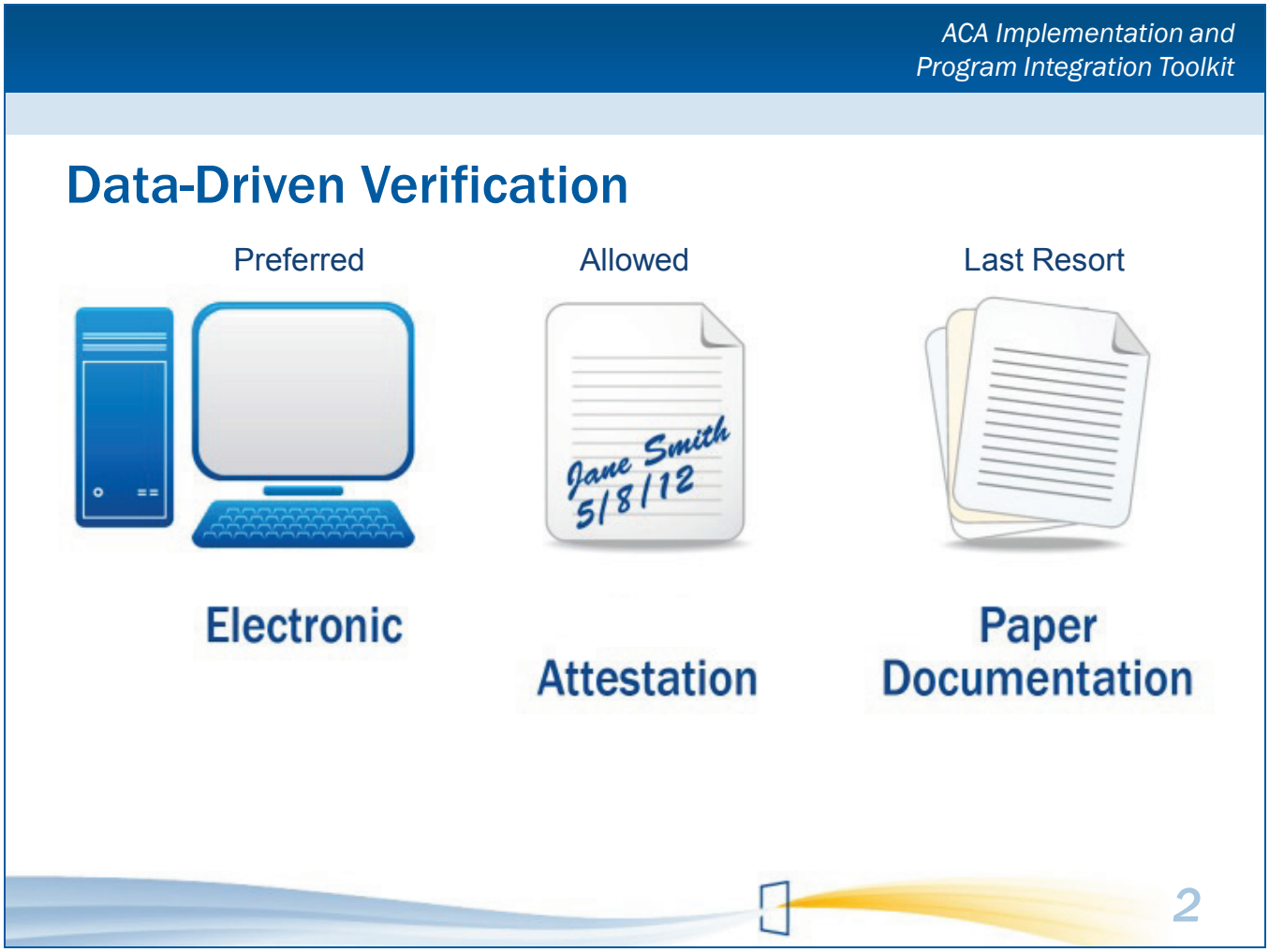
Policy Papers on Express Lane Eligibility

Building an Express Lane Eligibility Initiative: A Roadmap of Key Decisions for States, by Beth Morrow and Samantha Artiga, The Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, January 2010, http://www.childrenspartnership.org/AM/Template.cfm?Section=Publications&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=14646.

California's Express Enrollment Program: Lessons from the MediCal/School Lunch Pilot Program — And Suggested Next Steps in Making Enrollment Gateways Efficient and Effective, by Dawn Horner, The Children's Partnership, July 2006, http://www.childrenspartnership.org/AM/Template.cfm?Section=Publications&Template=/CM/ContentDisplay.cfm&ContentID=9682.

Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP, by Stan Dorn, Urban Institute, April 2009, http://www.maxenroll.org/files/maxenroll/resources/Auto-Enrollment%20April%202009.pdf.

Appendix 3.1: PowerPoint Slides on ACA Verification Requirements

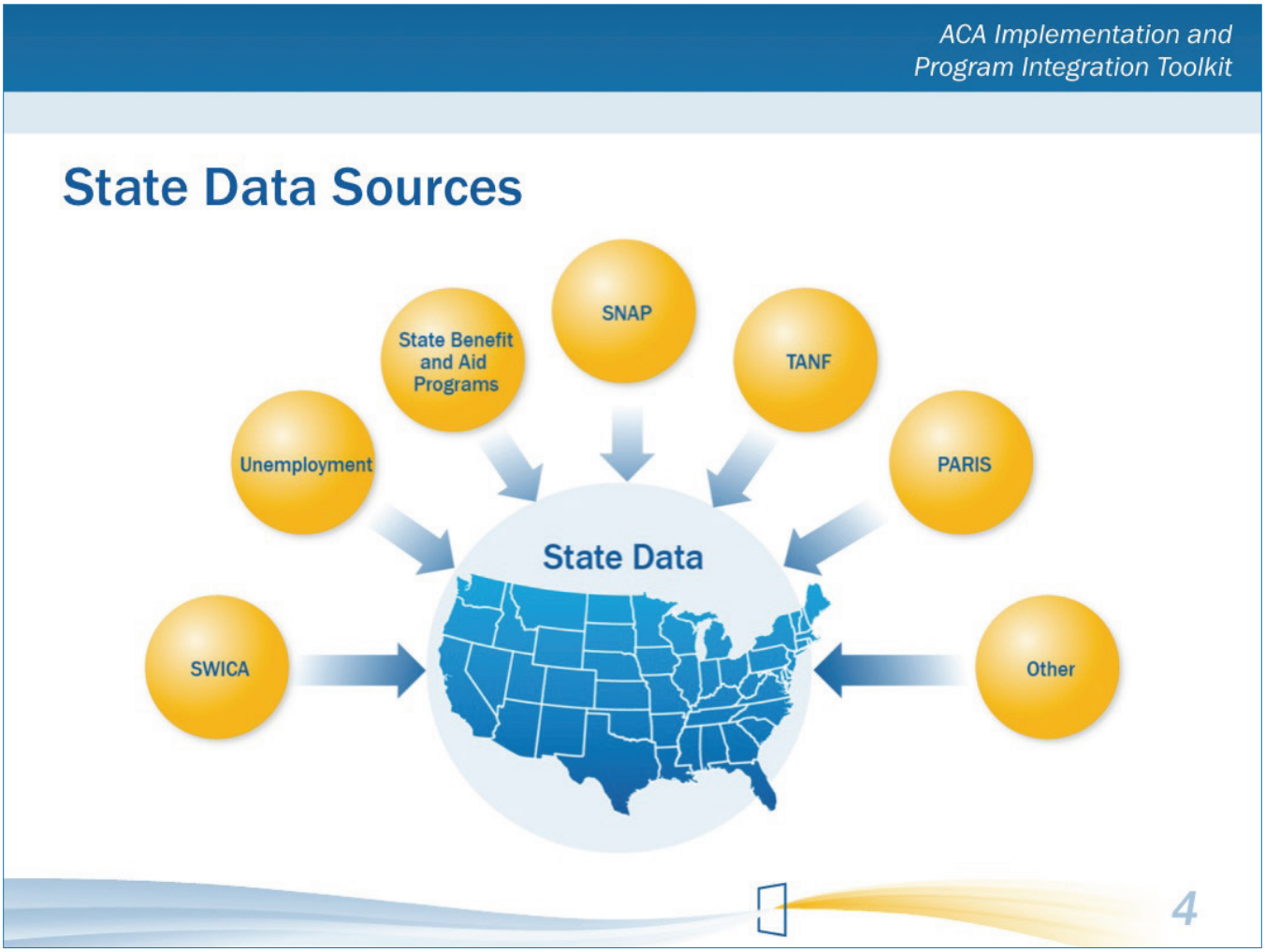


The ACA envisions a data-driven verification system:

- Medicaid and exchange rules require the use of electronic data and applicant/enrollee attestation in verifying eligibility information at enrollment and renewal to enable "real time" processing of applications.
- Rules also restate the longstanding policy that allows states to accept attestation as verification of most eligibility factors.
- Only when eligibility factors **can't** be verified by electronic data sources, can states request that consumers provide paper documentation.
- States must create verification plans that detail what data sources will be used and how they will be used. The plan does not have to be submitted for approval to HHS but should be made available to HHS upon request.

HHS will develop a "Federal Hub":

- States are required to use the "Federal Hub" to verify non-financial and financial information that is needed for Medicaid determinations.
- At a minimum, the "Federal Hub" will have access to:
  - The Department of the Treasury which can provide information about income from taxes
  - The Social Security Administration which can validate social security numbers, verify citizenship for many citizens and verify some income sources
  - The Department of Homeland Security which can verify immigration status



State Data Sources:

- In addition to verifying information available through the "Federal Hub," states must obtain financial information from key state resources to verify income and resources:
  - State Wage Information Collection Agency (SWICA)
  - Unemployment compensation agency
  - State-administered supplementary payment programs
  - State programs that provide aid to aged, blind and disabled
- States must also obtain information related to eligibility and enrollment from SNAP, TANF and other insurance affordability programs.
- Additionally, states must conduct data matching through Public Assistance Reporting Information System (PARIS).

Alternative Verification Process:

- States must use these sources and the "Federal Hub" to verify eligibility factors to the maximum extent possible, or alternatively they can use another process as long as it reduces administrative burdens on individuals while maintaining accuracy, confidentiality, coordination and minimizing delay.
- HHS must approve the alternative process.

Reasonable Compatibility

- States have some flexibility to define reasonable compatibility
- Income information is considered "reasonably compatible" if:
  - The electronic match and consumer statement are both either above or below the applicable income standard or other relevant threshold
- When information is not reasonably compatible, the state must seek additional information:
  - Statement explaining the discrepancy
  - Other information such as paper documentation

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Reasonable Compatibility:

- Does not mean a perfect match.
- States have some flexibility to define reasonable compatibility but it must consider a consumer statement about income and data source finding to be reasonably compatible if both are either above or below the applicable income standard.
- When the information provided by the consumer and the data source are not reasonably compatible, the state must seek additional information from the consumer, allowing him/her to explain the discrepancy or to submit paper documentation.

Appendix 3.2: Federal Verification Requirements in Medicaid and SNAP

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Items Needing Verification (note: for some eligibility factors, attestation is an acceptable form of verification)	• Income • Household composition • Citizenship or immigration status • Identity • SSN (for those who have it) • Disability • Age • State residency • Pregnancy • Deductions and disregards (e.g., child care expenses, child support payments received and paid) • Resources (e.g., savings accounts, etc.) • Third-party liability (access to other payer sources)	• MAGI-based income • Household composition • Citizenship or immigration status • Identity • SSN (for those who have it) • Age • State residency • Pregnancy • Third-party liability	Mandatory Verification: • Non-Exempt Gross income • Identity • Immigrant status of noncitizen applicants • SSN • Enrollment in a disability program • Residency (with some important exceptions) • Utility expenses if claiming more than the standard utility allowance • Hours worked, if subject to work requirements • Medical expenses if claimed • Child support obligation and payment if deduction claimed by non-custodial parent Only if Questionable (The state must set standards to identify what is questionable): • Dependent care expenses • Household composition • Resources • Shelter expenses • Citizenship For expedited service verification of all items other than identity can be delayed.

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Methods of Verifying Non-Income Information	• For citizen applicants, states can use data match with SSA. Other forms of documentation must be accepted as well. Immigrant applicants must provide satisfactory documentation and states must verify with DHS. Self-attestation alone is not allowed. • States have flexibility in the method for verifying all other eligibility factors, including the ability to accept attestation as form of verification.	• Focus on electronic verifications first, then attestation, and then paper documentation as a last resort. However, with a few exceptions (pregnancy and household composition, with some limitations), states are not required to accept attestation. • States must verify citizenship and immigration status through the federal hub (SSA and DHS). If not verifiable, can use other forms of documentation. Attestation alone is not allowed.	• Documentary evidence is the primary source of verification for everything except residence and household size (which can be collateral contacts). • Household has primary responsibility for providing documentary evidence, but the state must assist in obtaining verification and no one form of verification may be required. • The state will verify SSN with SSA. • Most States verify the validity of immigration documents through the DHS SAVE system. • States may use electronic verifications State agency can use third-party collateral contacts with household consent.

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Methods of Verifying Income- and Resource-Related Information	• Medicaid agencies must have an income and eligibility verification system (IEVS). Items related to determination of income must be verified to the extent possible. • States must verify information through the following sources: (1) State Wage Information Collection Agency (SWICA); (2) SSA and other wage databases; (3) Information about disability and SSI benefits from SSA; (4) Unearned income information from the IRS (5) Unemployment compensation information; (6) Additional income, resource, or eligibility information or correct amount of medical assistance payments available from other agencies. • With HHS approval, states may use alternative sources that are timely, complete, and useful for verifying eligibility.	• States must verify information through: (1) other state and federal agencies; (2) databases with information on wages, self-employment earnings, unearned income, and resources; and (3) Public Assistance Reporting Information System (PARIS); (4) SNAP, TANF, UI; and (5) other Insurance Affordability Programs. • Current requirements in Section 1137 of the Social Security Act continue. • States also have the option to rely on attestation. • States may use alternative databases so long as they reduce administrative burdens on individuals while maintaining accuracy and confidentiality and minimizing delays. HHS must approve such alternatives.	• Documentary evidence is the primary source of income verification, but no single form of verification may be required. When documents are insufficient for a determination, the state may use collateral contacts. • States may use electronic verifications • For income, the state must determine eligibility based on the best information available if the source of the income fails to cooperate and no other verification is available. • A state agency has the option to use IEVS. If it does, it must notify the household and explain that discrepancies will be resolved through collateral contacts.

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Addressing Discrepancies	• States define their own methods for determining whether documents and administrative verifications substantiate statements on applications.	• States cannot request additional documentation if information available through electronic data matching is "reasonably compatible" with information provided by the applicant. • "Reasonably compatible" does not mean an identical match but that information is generally consistent. Income obtained through an electronic data match or other verification is considered to be reasonably compatible with income provided by or on behalf of an individual if both are above or below the applicable income standard or other relevant income threshold • States must provide a reasonable time period to resolve discrepancies.	• When information provided by the household conflicts with other information, the household must have a chance to resolve it. The state has the option to verify the information directly prior to contacting the household. • During the certification period, when a state is unable to determine the effect on benefits of a change because the information is unclear, the state must issue a request to the household to verify or clarify with at least ten days to respond.

Appendix 3.3: Federal, State, and Commercial Electronic Sources of Information

Many information sources are available to verify income and other eligibility factors:

- **Federal databases.** States have long had access to many federal databases to verify items such as Social Security numbers, SSI and Social Security income, and Unemployment Insurance income. The health reform law will establish a federal hub which will contain information from SSA, IRS, and DHS.
- **State databases.** State databases have information on wages, addresses, new employment, motor vehicle records, drivers' licenses, child support income, workers' compensation, energy assistance, and some child care co-payments, among other items.
- **Commercial databases.** Payroll data companies, such as The Work Number (aka TALX), can provide employment and current income information for certain employers at certain cost to states.

The table below describes some of the federal, state, and commercial databases that states can use to electronically verify information from applicants in Medicaid and other human services programs.

Electronic Data Source	Information Contained in the Database	Accuracy / Timeliness of Information
Federal		
Social Security Administration (required in federal hub)	Person demographics, Social Security number, birth date, citizenship status, address, earned income, unearned income, Title II and Title XVI status, previous and scheduled payments, appeals and denial, Medicaid eligibility.	Real-time web service interaction available.
Homeland Security (required in federal hub)	Immigration status	Real-time through the federal hub
Internal Revenue Service (required in federal hub)	Federal taxpayer information, including the aggregate amounts of adjusted gross income of a taxpayer, adjustments to gross income, and tax-exempt interest.	Individuals file by April 15 for income in the preceding calendar year. Income information is only available on an annual basis.
Child Support, National Directory of New Hires	Includes quarterly state wage data, new hires data, and unemployment information from all 50 states and the District of Columbia.	Federal agency or payroll departments report within 20 days of new hire, and quarterly wage data no later than one month after end of calendar quarter. State agencies submit data within three business days after new hire data is entered into state directory of new hires. State wage agencies submit data within four months of the end of a calendar quarter, and Unemployment Insurance data within one month of the end of a calendar quarter.

Electronic Data Source	Information Contained in the Database	Accuracy / Timeliness of Information
Public Assistance Reporting System	Internal Revenue Service Homeland Security Social Security Administration National Directory of New Hires Electronic Verification of Vital Events Record System (EVVE) State Income and Eligibility Verification (IEVS) systems U.S. Postal Service Address Standardization	Matches conducted quarterly.
U.S. Postal Service Address Standardization	Contains address information.	
State		
IEVS	Used by states to compare data that applicants and recipients of welfare programs (TANF, SNAP, and Medicaid) supply with various federal data sources, including SSA and IRS. Note that IRS data through IEVS will likely include more information than what IRS will make available through the Federal Hub above.	
State Wage Reporting System	Includes quarterly wage reports for each employee who either resides or is employed in the state. Generally includes every form of remuneration of an employee, whether paid directly or indirectly, including salaries, commissions, and bonuses, and whether paid in cash or in-kind. Contains information on gross wages. Does not take into account most elective deferrals of compensation. Does not include contractor income, self-employment income, earnings across state lines, federal earnings, or earnings at multi-state companies (which report wages to just one state).	Information is submitted on a quarterly basis for a quarterly time period, and is typically reported 45 days after the end of a quarter. Report deadlines and the timeframe for posting reports to other state agencies may vary from state to state.
State Directory of New Hires	New hire data reported by employers in the state, which includes employee name, address, Social Security number, and information about the employer.	Information is reported within 20 calendar days after date of hire or by the first regularly scheduled payroll following the date of hire, if such payroll is after the expiration of the 20-day period. Employers reporting electronically must transmit information twice per month, no fewer than 12 and no more than 16 days apart. Information is available soon thereafter to benefit programs.

Electronic Data Source	Information Contained in the Database	Accuracy / Timeliness of Information
Unemployment	Contains Unemployment Insurance information on individuals who have received or applied for unemployment benefits, as reported by state welfare agencies. Includes individual's name, Social Security number, address, benefit amount received (gross amount before any deductions), and reporting period for when the unemployment insurance claim was filed.	Capability for real-time queries may vary from state to state.
Bureau of Vital Statistics	Has information on births, deaths, marriages, and divorces.	
Department of Motor Vehicles	Maintains address and some asset (e.g., automobiles) information.	
Commercial		
TALX Work Number	Contains employment and income records for more than 190 workers and more than 2,000 employers (15 percent to 20 percent of national employed workforce). Largely represents information from large employers and Fortune 1000 companies. Provides information on employee name and Social Security number, employment status, most recent start date and termination date (if applicable), total time with employer, job title, rate of pay, average hours per pay period, total pay for past two years, and the most recent 12 pay periods of gross earnings.	Information is updated when an employer processes payroll. Can be queried daily, weekly, or monthly depending on system setup. Web application also available to perform queries on a single individual, as well as real-time web service to support system to system queries. States can opt for several different levels of service. State agencies are charged for use.

Renewals

Background

All individuals and families must periodically renew their eligibility for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and other benefit programs. This step ensures that households remain eligible and that they are receiving the correct amount of benefits. While the renewal process is important, it can result in eligible families losing their benefits because they are unable to successfully complete it. Oftentimes, administrative rules and procedures that families must meet to retain benefits prove overly complex and burdensome. As a result, some families lose eligibility only to apply again within a few weeks. Not only is this type of "churning" disruptive for families, it is also an enormous waste of caseworker and agency time.

Fortunately, new rules adopted to implement the health reform law will streamline the Medicaid renewal process, making it much easier for families to keep their benefits starting in 2014. States will renew eligibility by first evaluating electronically available information. If that information is sufficient to determine Medicaid eligibility, the agency will renew eligibility and send the appropriate notice informing the family of the renewal and explaining the basis for that renewal. The individual will not need to take any action unless there are inaccuracies in the information provided on the renewal form. If the agency is unable to determine ongoing eligibility based on the data available, it must give families the opportunity to renew eligibility using multiple modes — in person, online, by telephone, or by mail. The agency must first send forms that are pre-populated with available information and provide the individual with reasonable time to correct any inaccuracies and provide any additional required information. The agency must then verify the information the individual provides, unless it has opted to use self-attestation to establish the relevant eligibility factor.

For many poor families, simplifying Medicaid renewals will not be enough, because they must also renew their eligibility for other programs. Much can be done to coordinate the process of renewing benefits across programs, which can vary widely. For example, in SNAP, states must use fixed certification periods (no longer than 12 months for most participants) and must obtain a new, signed form from the family at the end of the certification period. In addition, households need to report on changes on income, household composition, and a few other matters at 6 months. Most states' Temporary Assistance for Needy Families (TANF) and child care subsidy programs also use fixed eligibility periods, though they are not required to do so, and the time periods and paper requirements may be different. In health coverage programs (except for Medicaid beneficiaries who qualify based on disability or who are 65 years and older), federal rules require redetermination of eligibility no more than once every 12 months, and families are considered eligible until they are shown to be ineligible because of changes to their income or circumstances or because they do not complete the renewal process. (See Appendix 4.1 for a comparison of federal Medicaid and SNAP renewal requirements). Consequently, coordinating eligibility requires that states find a way to incorporate these varying requirements into a coherent process that reduces the burden on both families and caseworkers.

Reporting Changes

People enrolled in Medicaid will still be required to report changes that affect their eligibility. States will need to establish processes to facilitate the reporting of such changes. To the extent that states have integrated these processes across multiple benefit programs (i.e., a change reported for SNAP can also trigger a change in Medicaid or vice versa) they will need to address that in the new system.

Fortunately, states have significant flexibility — particularly in renewal of health care coverage — to coordinate and streamline renewals. For example, when updated information is collected for SNAP, states can extend

eligibility for Medicaid and the Children's Health Insurance Program (CHIP) without requiring a separate renewal process — a strategy that is sometimes called "rolling renewal." Under this approach, when a family recertifies its eligibility for SNAP (or submits the required reports within the certification period) the state can use the information gathered as part of the SNAP renewal to redetermine eligibility for Medicaid and bump forward the family's Medicaid or CHIP eligibility period for another 12 months without requiring the family to submit additional paperwork. This strategy also can be used if eligibility periods fall out of alignment: they can be quickly realigned by pushing the Medicaid eligibility forward.

States can pursue additional strategies to streamline renewals. This module provides a framework for a guided process that agencies can use to review their current process for conducting renewals, and design a new process that both meets the Affordable Care Act (ACA) requirements and makes it easier for families to renew their eligibility for multiple programs.

Goals

This module will help states:

- Become familiar with the new renewal requirements under the ACA.
- Conduct a review of the state's current practices for renewing Medicaid eligibility and identify opportunities for synchronizing renewals.
- Convene a group of experts to design a renewal process that will comply with the new ACA requirements.

Tools and Resources Included in this Module

1. **Presentation:** Review new ACA requirements for renewing eligibility in Medicaid.
2. **Exercise 1:** Review current state policies and processes for renewing eligibility in programs.
3. **Exercise 2:** Identify changes that need to be made to Medicaid renewals in preparation for 2014.
4. **Wrap-Up and Next Steps:** Identify guiding principles for the renewals process that need to be taken into account during implementation planning.

How to Complete This Module

As a first step, establish a renewal workgroup. Involving a diverse group of experts and stakeholders will ensure that your group discussions are considering all aspects of the work. You may also want to involve an outside facilitator if resources allow. Consider involving the following representatives:

- Medicaid, CHIP, and SNAP policy experts (you will want to include experts from other program areas if your state plans to coordinate renewals across more programs)
- Representatives from your state's exchange organization
- Operational managers and caseworkers who oversee renewals now
- Data analysts who can help assemble data on renewals

- Quality assurance representatives
- Staff or labor union representatives
- Individuals with IT expertise if you are considering the use of automation tools to streamline renewals

At the end of this section, we suggest additional background materials you may want to distribute to the group.

Each of the exercises involves holding one or more workgroup meetings. We estimate you will need to schedule approximately eight hours of workgroup meetings to complete this section. You may choose to schedule them in a series of shorter meetings or as one all-day session, depending on your convenience.

Questions have been provided in each exercise to guide your conversations. As you work through discussion questions, make sure to take note of key decisions, unresolved issues that need further attention, and action steps that need to be taken to move forward with planning and implementation.

In addition, in the instructions for some of the exercises, we include tables you can use to gather background information that will help inform your workgroup discussions. Allow yourself and your team an appropriate amount of lead time to gather this data.

As always, you should feel free to modify and add to the materials and exercises provided in this module to suit your state's specific needs and circumstances.

Presentation

Review new ACA requirements for renewing Medicaid eligibility

We recommend starting with a presentation designed to familiarize your workgroup members on the basic requirements that states will have to meet. This can serve as a jumping off point for a more detailed discussion on how to design a renewal process for Medicaid in 2014. Template PowerPoint slides (with notes) for this presentation are provided in Appendix 4.2.

You may choose to modify the presentation to suit the level of familiarity that your workgroup members have about the ACA's renewal requirements, but at a minimum, we recommend covering the following points:

- Starting in 2014 Medicaid renewals cannot be required more often than once every 12 months for individuals who qualify for Medicaid based on Modified Adjusted Gross Income (MAGI) methodologies.
- Beneficiaries must report changes that may affect eligibility and states are required to act on changes that may affect eligibility.
- If the state determines that the individual is no longer eligible for Medicaid, the agency must assess if he/she is eligible for other insurance affordability programs (CHIP, premium credits, etc) and electronically transmit all relevant information to the other program as applicable.
- Every 12 months, states must conduct back-end verification using data available to the agency. The state will then notify beneficiaries if they have been found eligible or ineligible for Medicaid, along with the basis of their determination.
- The beneficiary only needs to notify the agency if any information is inaccurate. Otherwise, the client is not required to take action (no signature or return of the notice is required if the information is accurate) to have his/her eligibility renewed.
- If the state does not have sufficient information to determine ongoing eligibility using electronic data sources, the state must send beneficiaries pre-populated forms to complete.
- States must allow clients to renew using multiple modes — in person, online, by telephone, and by mail.

Exercise 1

Review current state policies and processes for renewing eligibility in programs

The goal of this exercise is to assist your workgroup in reviewing your state's current policies and processes for conducting renewals in Medicaid. It is intended to provide a starting point for identifying changes your state will need to make to meet the new ACA requirements and decide about ACA options governing renewals, and to identify opportunities for coordinating the renewal process across multiple programs. Completing Exercise 1 should provide you with a good sense of what happens at renewal, how well the process works, and areas that need improvement.

Gather Background Information

The first step is to gather administrative data you may already have on Medicaid renewals. Some of the more common workload retention and churn measures related to renewals are included in the table below. Additionally, in order to determine the efficiencies that could be gained by aligning renewals between Medicaid, CHIP, SNAP, and other programs you will need data on program overlap, which this table also helps you address by suggesting that you compare these elements across programs. You may have additional data you would like to include, but Table 1 provides you with a starting point. We recommend assigning this as background research to one or two workgroup members representing each program area. Even if you are able to complete only a portion of the table, the findings will be beneficial to the process.

Table 1. Data on Renewals

	Medicaid for Children and Families	All Other Medicaid	CHIP	SNAP	Other
Number of renewals processed per month					
Average length of time it takes to process a renewal					
Proportion of renewals approved per month					
Number/percent denied per month					
Proportion of denials that were based on a finding of ineligibility					
Proportion of denials that were based on procedural reasons (e.g., failure to submit documentation)					
Proportion of cases denied that reapply within 30/60/90 days					

After gathering the information in Table 1, the next step is for key workgroup members to review and document the state's current processes for conducting renewals. Below are some questions that may be helpful in understanding your processes. Workgroup members should be given adequate time to consider these questions and should come prepared to share their findings during the first workgroup session.

Questions on Current Process for Renewing Medicaid

Key Questions: *How are Medicaid renewals conducted now? Are renewals centralized? Or are they done by local offices?*

Notes:

Key Questions: *What modes (e.g., in-person, by mail, by phone, etc.) are available for clients to complete the renewal process? What percentage of beneficiaries renews eligibility using each available mode?*

Notes:

Key Questions: *What eligibility factors must be re-verified at renewal? Are all of these factors likely to change over time?*

Notes:

Key Questions: *What existing data sources does the state use to verify information at renewal? When (if at all) does the state renew eligibility without asking the consumer to provide additional information or return forms?*

Notes:

Key Questions: *What is the process for sending out renewal packets and notices? When are these packets and notices sent to beneficiaries? How much time do beneficiaries have to respond?*

Notes:

Key Questions: *What steps does the agency take to encourage consumers to respond to renewal notices? Does the agency call households and encourage individuals to provide information by phone?*

Notes:

Key Questions: *What happens when clients do not complete the renewal process by the deadline? Does the agency follow up with people who do not complete the renewal process?*

Notes:

Key Questions: *Is there a grace period for reinstating eligibility without requiring a new application? Can a caseworker reopen a case that was closed because of failure to complete the renewal, or must the caseworker start a new application?*

Notes:

Key Questions: *What renewal-related information does the state monitor? Is there information about the proportion of cases that reopen within several months of closure? What does the information say about how well the renewal process is working?*

Notes:

Key Questions: *Considering the data collected in Table 1, are there programs obtaining significantly better results in maintaining eligible persons enrolled at renewal? If so, what could be contributing to the difference in results?*

Notes:

Key Questions: *What are the major contributing factors for procedural closures — that is, cases that are closed because of failure to complete the renewal process rather than a finding of ineligibility? Have any programs had success in addressing these issues?*

Notes:

Key Question: *How coordinated is the Medicaid renewal process with renewals for other benefit programs for clients receiving multiple benefits?*

Notes:

Key Questions: *Does the state synchronize Medicaid renewals with renewals for other human services programs? Does the state use information from SNAP to push forward a Medicaid renewal?*

Notes:

Key Question: *Does the state use Express Lane Eligibility for CHIP or other procedures to use data from one program to make determinations for another at renewal?*

Notes:

Exercise 2

Identify changes that need to be made to Medicaid renewals in preparation for 2014

After completing the tasks in Exercise 1, the next step is to devote about two hours of the workgroup's time to consider the information that has been gathered and have a discussion about your state's current verification processes — how well do current processes work and how can they be improved? Make sure that all your workgroup members have copies of the tables that were completed in Exercise 1, along with all the other supporting materials, such as copies of renewal policies and procedures, renewal forms, and notices.

To help guide your discussions, we have provided a series of questions below. These questions are intended to help you assess your renewal processes and identify gaps that you might want to consider addressing. Some of these questions are also designed to help you think through how well your current process fits the new Medicaid rules for how renewals should be conducted in 2014.

Discussion Questions on Improving Renewals

Key Questions: *What aspects of current renewal processes are working well? Where is there room for improvement?*

Key Discussion Points:

Key Questions: *What ACA requirements for renewal are already being met? How well does the state perform these requirements?*

Key Discussion Points:

Key Question: *What ACA requirements will be new for the state?*

Key Discussion Points:

Key Question: *What does the state need to do to implement data-driven renewals as required by the ACA?*

Key Discussion Points:

Key Questions: *What opportunities exist for coordinating the Medicaid renewal process with renewals for other benefit programs for clients receiving multiple benefits?*

Can human services programs use Medicaid findings to renew eligibility for their programs and services?

Can human services programs implement ACA renewal procedures (e.g., reliance on data-driven renewals, use of pre-populated forms, etc)?

Key Discussion Points:

Wrap-Up and Next Steps

Identify guiding principles for the renewals process that need to be taken into account during implementation planning

The goal of this exercise is to consider the information and discussion from the previous exercises, and begin thinking about an overall approach to conducting renewals in 2014. For this exercise, you will want to engage policy, operations, and IT experts who are familiar your current Medicaid system. It would also be wise to invite policy experts from human service programs — especially SNAP — if you intend to create a process that is aligned across programs. Below are some questions to help guide your discussion.

Discussion Questions on Developing an Overall Approach to Renewals

Key Questions: *What aspects of the current renewal process work best and should be retained? What can be improved?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Questions: *What changes will the state need to make to its renewal process to comply with ACA requirements? What changes would be needed to implement the ACA renewal options that the state is seriously considering?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Question: *What other new processes can be put in place to make renewals easier for consumers?*

Key Decisions:

Decisions Pending:

Next Steps:

Key Questions: *Will the state try to synchronize renewals across Medicaid and other programs? What strategies can be used to do that? How will the state modify its renewal rules and processes for human services programs in view of the ACA?*

Key Decisions:

Decisions Pending:

Next Steps:

Resources

Regulations and Guidance

Medicaid Eligibility Final Rule 42 CFR Parts 431, 433, 435, and 457 "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010," U.S. Department of Health and Human Services, March 16, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

Exchange Eligibility Final Rule 45 CFR Parts 155, 156, and 157 "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," U.S. Department of Health and Human Services, March 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's August 17, 2011 Proposed Rule and Key Issues to Consider, by MaryBeth Musumeci, Samantha Artiga, and Robin Rudowitz, Kaiser Commission on Medicaid and the Uninsured, October 2011, http://www.kff.org/medicaid/upload/8254.pdf.

Policy Papers on Increasing Retention

Easing Benefit Enrollment and Retention by Reducing the Burden of Providing Verification, by Liz Schott and Sharon Parrott, Center on Budget and Policy Priorities, December 13, 2005, http://www.cbpp.org/files/12-13-05prosim.pdf.

How States Can Align Benefit Renewals Across Programs: Options for Simplifying and Aligning Eligibility Reviews, by Elizabeth Schott and Sharon Parrott, Center on Budget and Policy Priorities, June 20, 2005, http://www.cbpp.org/files/4-27-05prosim.pdf.

Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at a Critical Moment, by Dottie Rosenbaum and Stacy Dean, Center on Budget and Policy Priorities, February 24, 2011, http://www.cbpp.org/cms/index.cfm?fa=view&id=3408.

Medicaid and CHIP Retention: A Key Strategy to Reducing the Uninsured, by the Southern Institute on Children and Families, March 2009, http://www.thesoutherninstitute.org/docs/publications/MedicaidCHIPRetention.pdf.

The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP, by Tricia Brooks, Georgetown Center for Children and Families, February 2009, http://ccf.georgetown.edu/index/cms-filesystem-action?file=postcards/the%20louisiana%20experience.pdf.

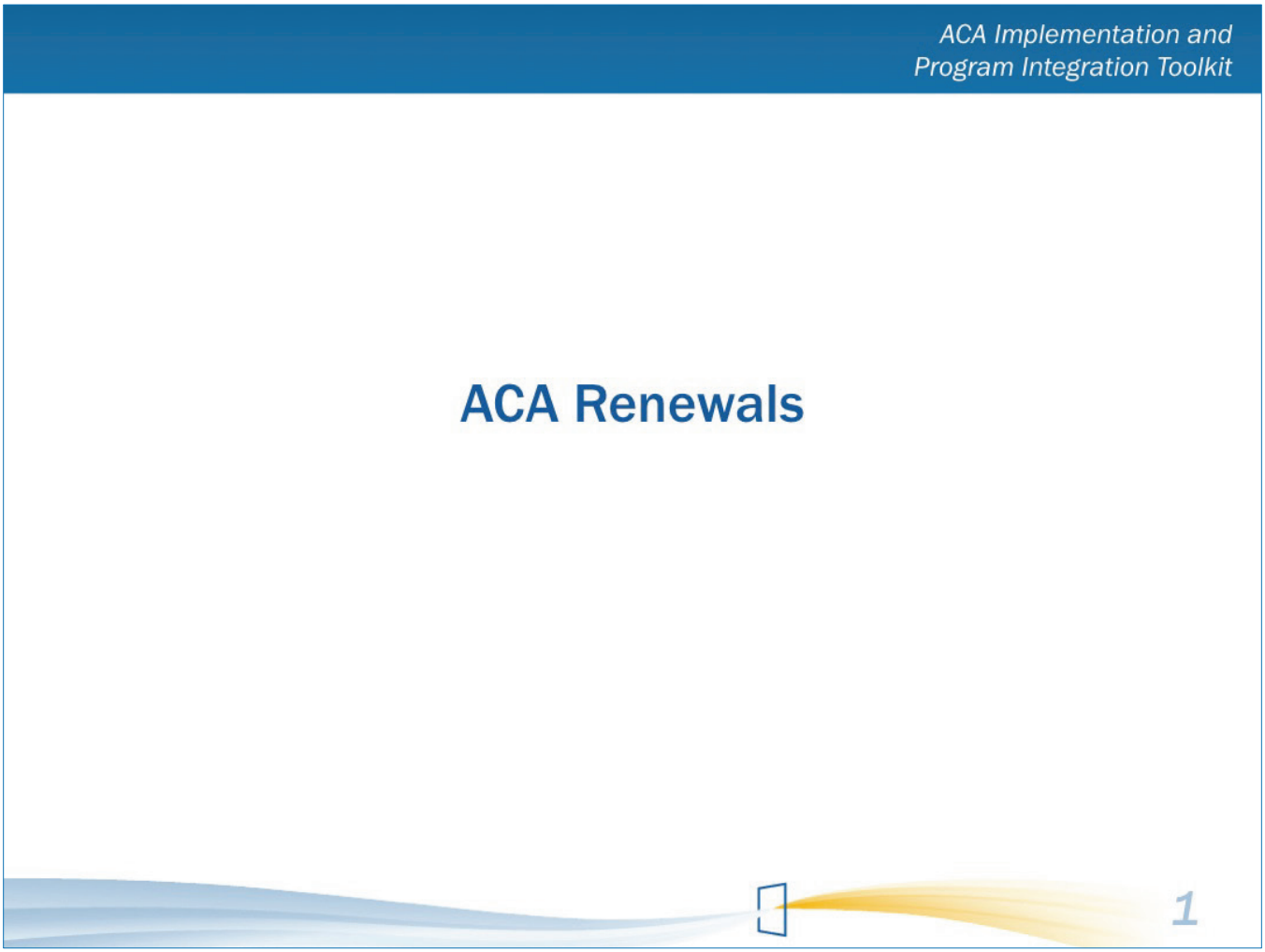
Appendix 4.1: Federal Medicaid and SNAP Renewal Requirements

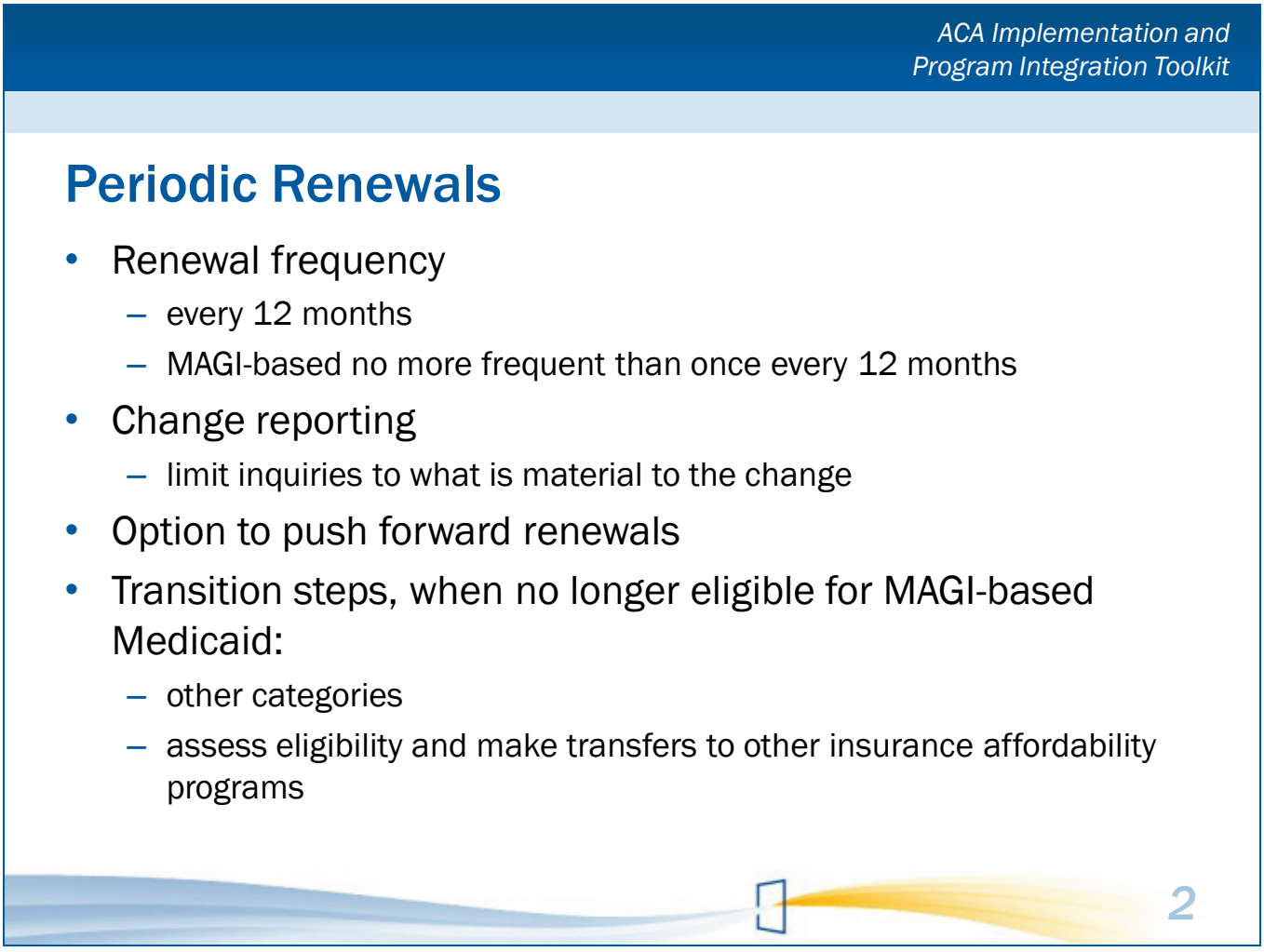
	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Certification Periods	State must redetermine eligibility at least every 12 months. States have a lot of flexibility in designing their periodic review processes and procedures. For example: • Some states use rolling renewal where at any time the Medicaid agency has sufficient information to process eligibility; the state uses that information to push forward the next scheduled renewal date. • For children, Medicaid agencies can implement continuous eligibility.	States cannot conduct redeterminations more often than once every 12 months unless there is information about a change in circumstance that would affect eligibility. • States can use rolling renewal if the Medicaid agency has sufficient information to process eligibility without requiring additional information from the beneficiary they can push forward the next scheduled renewal for another 12 months.	States can choose certification periods of up to 12 months for most households. Elderly or disabled households with no earnings may be certified for up to 24 months. Most states choose simplified reporting with six-month certification periods or 12-month certification periods and a six-month interim report (see below). States have the flexibility to align certification periods with health programs (The Food and Nutrition Service has approved waivers to allow states to start a new certification period when the state is conducting a renewal for another program.)

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Reporting Requirements	Beneficiaries must make timely and accurate reports of any change in circumstances that may affect their eligibility and states must act on such changes.	Beneficiaries must make timely and accurate reports of any change in circumstances that may affect their eligibility and states must act on such changes.	Almost every state uses "simplified reporting." • Changes in household composition, income, and residence must be reported every six months on a report form or through the recertification process and states must act on these changes. • Otherwise, over the six-month period only increases in income above 130 percent of poverty must be reported. States may act on other reported changes that increase or decrease benefits, or may choose to act only on changes that increase benefits.
Format for Conducting Redeterminations	Some states have begun giving consumers the option to complete reviews through a variety of formats, including telephone and online. Interviews can be required at the state option.	Beneficiaries must be allowed to complete renewals online, in person, by telephone, or by mail. Interviews cannot be required.	A recertification application with a signature (can be electronic or telephonic) must be submitted — in person, by mail, or online. An interview is required at least every 12 months, but can be done by telephone. The household has a right to an in-person interview.

	Current Medicaid Requirements	Future MAGI Medicaid Requirements	SNAP Requirements
Process for Conducting Redeterminations	States are required to conduct ex parte reviews of ongoing eligibility to the extent possible. Agencies must use information available to them, including looking to see if they have information from other benefit programs, wage reporting, SSA, etc. Some Medicaid agencies use pre-populated forms that include all information the state has about the beneficiary. States sometimes require beneficiaries to return the form only if a change has occurred in their circumstances; other states always require beneficiaries to return the form.	New rules establish a Medicaid administrative renewal process requiring states to use available databases for eligibility verification. Every 12 months, states must conduct back-end verification using existing information available to the agency. The state will then notify the individual that they have been found eligible for Medicaid and the basis of their determination. The individual must notify the agency (online, by phone, by mail, in person, or by fax) if any information is inaccurate but is not otherwise required to take action (no signature or return of the notice if the information is accurate). If the state cannot determine Medicaid eligibility through administrative renewal, it must send a pre-populated recertification form. The beneficiary has 30 days to recertify.	The state must notify the household and provide a recertification application and a list of required verifications. States have the flexibility to: • Align certification periods with health programs (The Food and Nutrition Service has approved waivers to allow states to start a new certification period when the state is conducting a renewal for another program.) • Combine renewal with other programs. • Allow renewals by telephone or online (the required signature can be submitted this way).

Appendix 4.2: PowerPoint Slides on ACA Renewal and Change Reporting Requirements





Eligibility must be renewed once every 12 months:

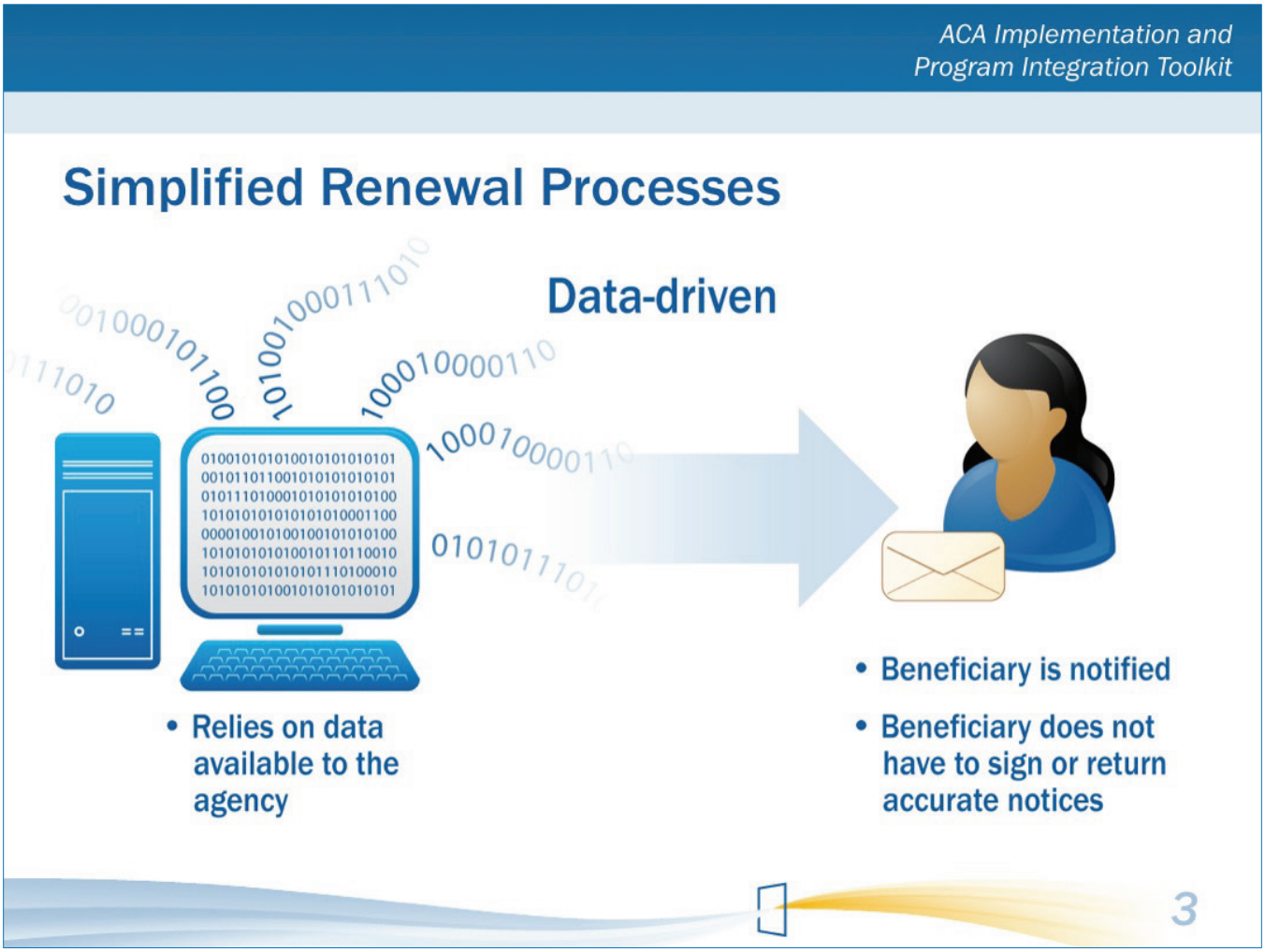
- For both MAGI and non-MAGI groups.
- For those whose eligibility is based on MAGI, the scheduled renewal can be no more frequent that once every 12 months.

States must have processes and procedures in place to ensure that beneficiaries report any changes in their circumstances that may affect eligibility:

- For those whose eligibility is based on MAGI, when a change occurs within a renewal period, states must limit information requests of the beneficiary to what is material to the change.
- However, if the agency has enough information to complete a full renewal, it can do so and push forward the next renewal date. For example, if the agency gets all of the information it needs from information provided to make an eligibility determination this allows for synchronization of renewals with other benefit programs.

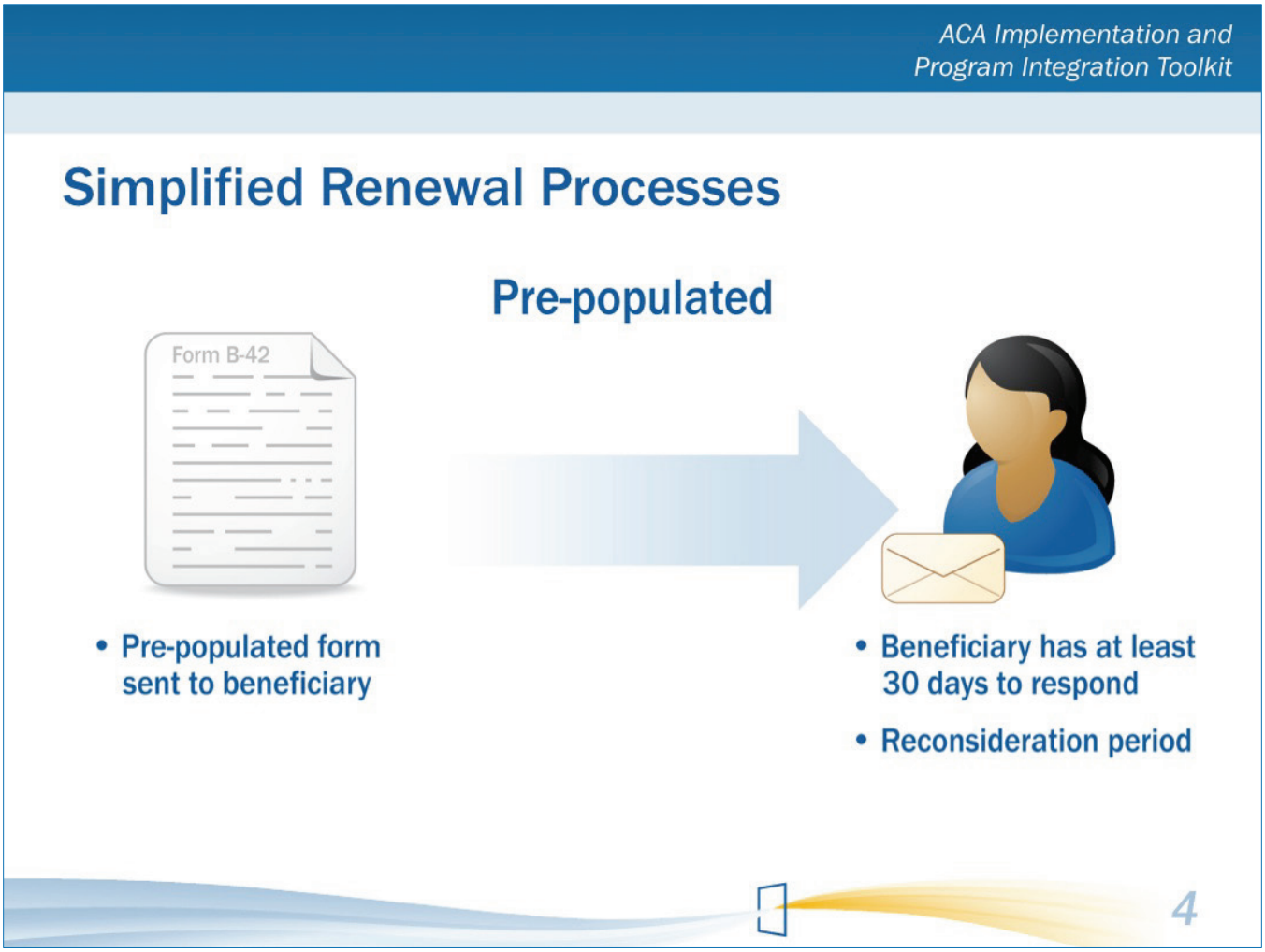
When beneficiaries are no longer eligible:

- If the agency determines that the individual is no longer eligible for Medicaid, the agency must assess if he/she is eligible for other insurance affordability program (CHIP, premium credits, etc) and electronically transmit all relevant information to other programs as applicable.



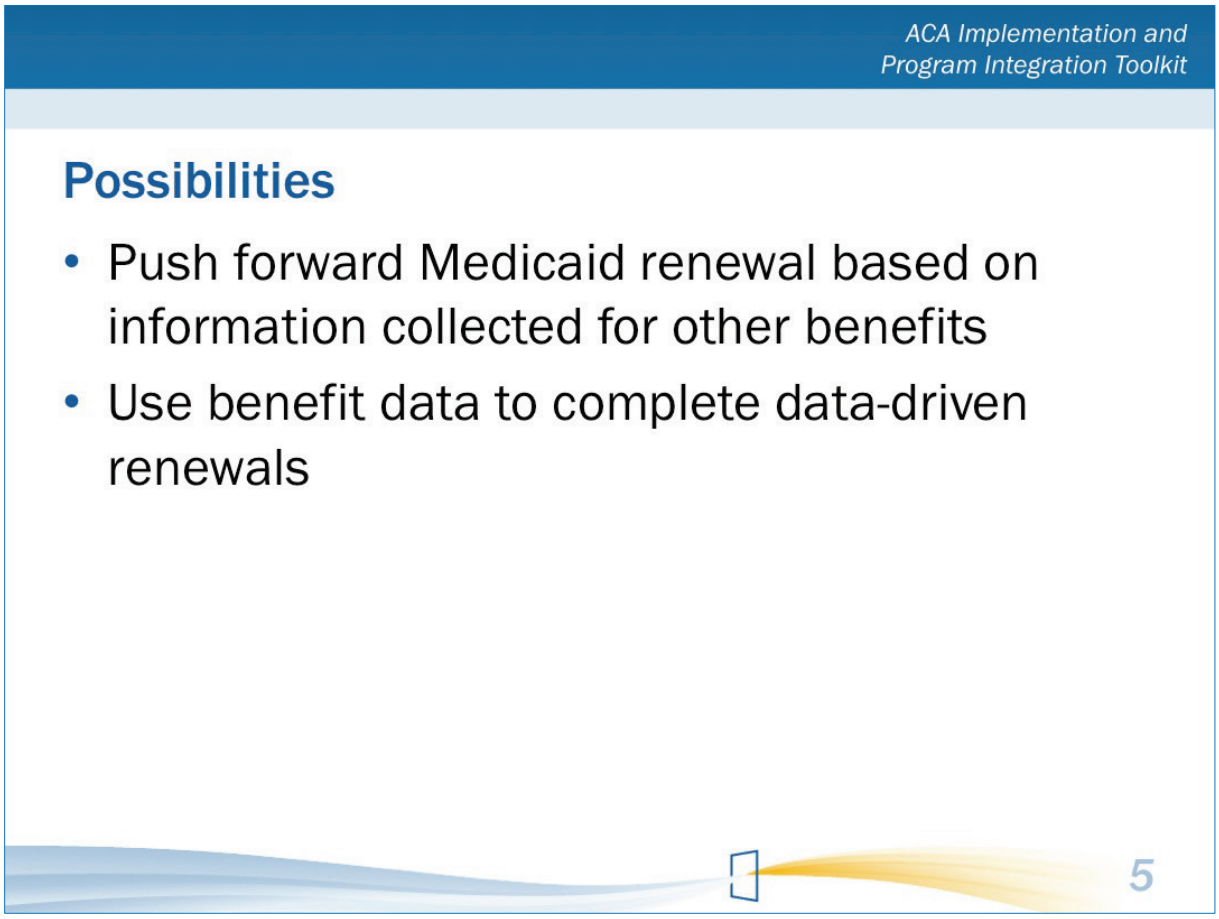
The new rules for renewals focus on simplifying the renewal process for consumers and maximizing the use of third party data sources. Data-driven renewals are required for both MAGI and Non-MAGI:

- At the time of renewal if the state has enough information in the case file and/or data sources, then the state must use this information to complete the renewal for beneficiaries.
- The state sends the beneficiaries a notice with the decision and information used to make the determination.
- If the information used to make the determination is accurate, the beneficiary does not have to sign or return the form.
- If the information used is not accurate, then the beneficiary must inform the agency and must be able to do so online, telephone, in-person or other electronic means.



The use of pre-populated renewals is required for Medicaid based on MAGI and is at the state's option for non-MAGI:

- Agencies must send beneficiaries pre-populated renewal forms containing information available to the agency that is needed to renew eligibility. HHS will specify what information will be needed.
- Beneficiaries must be able to respond online, via phone, mail, in-person and sign the form using electronic and telephonic formats as well as handwritten.
- Beneficiaries must be given at least 30 days to respond and provide any necessary documentation.
- If the beneficiary fails to respond in this timeframe, but responds within 90 days (90 days is a minimum, states can choose a longer period) of the termination the state must "reconsider" them without requiring an application.
- Agencies must notify the beneficiary of the decision.



Pushing forward Medicaid renewals:

- Although MAGI-Based Medicaid only allows for renewals to occur no more frequently than once every 12 months, if the state has information about a change and has everything it needs to re-determine the case, then it can push forward eligibility another 12 months.
- That means if SNAP collects everything needed for Medicaid during a SNAP 6 month report, Medicaid eligibility can be determined and pushed forward.

Using data from other benefit programs:

- States are required to use data from SNAP to the greatest extent possible to make determinations. This is very important because most people enrolled in SNAP are very likely to meet the applicable income standard for MAGI-Based Medicaid.
- However, differences in how income is counted and household units might make using this data a little challenging. Key things to note are that:
  - For the most part SNAP will count more income sources than MAGI-Based Medicaid
  - SNAP households are related to who lives and eats together along with some relationship factors and MAGI based Medicaid will calculate households by relationship of people living together and tax filing.
- States can explore which groups enrolled in SNAP and TANF are always going to meet the applicable Medicaid income standard and find a way to simply determinations for these groups, for example:
  - If the income total income for the family is less than 138% of the FPL for a family size of one, then no need to reconfigure the households, everyone meets the MAGI-Based Medicaid income standard.

Staff Readiness

Background

Well-designed policies, processes, and technology tools are important to ensure that a service delivery system is administratively efficient and effectively connects eligibility low-income families and individuals to benefits. A crucial element of successful implementation, however, will be preparing agency staff to take on new roles and responsibilities. They must understand their agency's goal, their personal role, and their performance expectations in order for the new system to work. This is always true when large-scale change is anticipated, such as the rollout of required changes to Medicaid in 2014 and even more true when complex multi-program systems changes will be undertaken, such as program integration. This section contains key questions related to defining roles, staff performance expectations, supervisory expectations, and training that your state's implementation of eligibility and enrollment under health reform will require.

As states consider how best to implement changes to their eligibility and enrollment systems required by health reform, they may be considering an entirely new way of doing business. As discussed in the Eligibility module, the new law provides an opportunity for states to consider their business model. And, many states have already had significant success in improving their efficiency with different approaches to processing eligibility. New business processes, IT systems, electronic case files, and better sources of electronic verification have allowed states to design their service delivery models in more flexible ways. Some states have moved away from traditional case management models, where staff carry a fixed caseload and are responsible for all components of eligibility determination for their clients. New service delivery models include universal caseloads where tasks can be assigned to any qualified worker in the state or county, task-based work models in which workers specialize in a part of the eligibility process rather than carrying an alpha-caseload, and regional or centralized services like call centers and centralized mailrooms. For example, electronic case files and offering interviews or customer assistance by telephone give states the flexibility to organize their work regionally or in a centralized processing center. Work can be assigned to units with more current capacity, unlike under the more traditional case management model where work volume depends on who comes through the local office door on a given day. The new business models require rethinking staffing methods, training, and performance management.

While modern systems and business processes are giving states more flexibility to respond creatively to increasing workloads, they also require highly trained staff who have the knowledge and confidence to adapt to the flexible system when their job duties change. This is especially important when considering how to approach program integration. It's possible to have an integrated system from the client's perspective, but split the eligibility determination among workers who specialize by program. But program specialists need to know enough about other benefit programs that they can connect clients who aren't participating, and they need to have the training to be able to be reassigned to another program depending on workload.

Once agencies have made decisions about their new business processes, they will need to think about how to prepare staff and supervisors for their new roles. A staff readiness plan typically addresses staff roles and responsibilities, staff performance management, training needs, and supervisor readiness.

- **Staff roles and responsibilities.** Staff roles and responsibilities are usually defined by position descriptions and organizational structure. Traditionally, eligibility and enrollment job classifications include clerical staff, eligibility specialists, lead workers, and supervisors. States that have redesigned their business processes use the same positions, but redefine the roles. For example, clerical staff who are no longer needed to support case workers now work in centralized mail processing units or answer

basic questions through a toll-free customer service center. The role of eligibility specialists also changes dramatically in new business models. For example, rather than working on all aspects of eligibility, staff in some task-based business processes specialize in intake interviews in storefronts or toll-free phone intake centers, or conduct batch processing in case maintenance units.

- **Supervisor readiness.** Preparing supervisors for change is especially critical, as they will be primarily responsible for helping their staff successfully transition. In addition to training on policy and process changes, they will likely need to gain new skills related to balancing work among new work units. To be successful, task-based models require close teamwork among unit supervisors in order to flex the model as the workload shifts, which may require new skills. They will also need to be trained in using new data and reports to effectively manage staff performance. Supervisory training is typically delivered first, and should include information on how to help staff cope with change.

- **Staff performance management.** When states change their business models, they also need to change the way they assess performance. Traditionally, staff performance is measured at annual reviews and focuses on a few objective measures of performance like case accuracy and caseloads, attendance, and interpersonal skills. A newer approach to measuring staff performance in a task-based work model is to focus on customer service and performance measures of productivity by measuring things like the number of completed tasks *per worker per day*. Agencies using this approach have not replaced their annual review processes, but have refocused them on measuring staff success at providing excellent customer service and connecting eligible people to benefits quickly. If productivity is being measured daily, then the annual review can be a time to focus on the employee's development needs and career goals, and how much they contribute to the agency's core mission and goals.

- **Training needs.** A good staff training plan includes an inventory of staff training needs, an outline of the curriculum that will address the needs, a description of the training delivery methods and activities, and timeline for training delivery. In addition to the state's business model for health reform, staff will need training on new IT systems, new Medicaid policies, and changes to their business processes. They will likely also need additional "soft skills" training. Soft skills training for staff could include the agency's new customer service philosophy and standards, coping with change, being a good team player, and dealing with difficult customers. Supervisor training is an important part of a state's approach, as well.

Goals

This module will help states:

- Assess their current staffing, including types and number of positions, workload and performance expectations, and training plan.
- Convene a group of people to make recommendations on changes needed to current position descriptions, performance expectations, and organizational structure.
- Develop the framework of a training plan for eligibility staff and supervisors.

Tools

This module includes the following tools:

1. **Exercise 1:** Assess your current staffing model

2. **Exercise 2:** Host a staff readiness planning meeting

3. **Wrap-Up and Next Steps:** Outline a training plan for staff and supervisors

How to Complete This Module

This module provides you with tools and suggestions for a guided process you can use to review your current staffing model and prepare the people in your organization for changes in their job duties. This tool is designed to be used after you have a good sense of your future eligibility and renewal practices.

Operational managers and representatives of each of the job classifications that will be affected are the most important stakeholders to involve in developing your staff readiness plan. You will also want to involve your human resources department and labor relations specialists if you have collective bargaining agreements that will be affected. It would be advisable to invite policy experts who have been involved in the workgroups that have redesigned your service delivery model as a resource for the discussions.

To complete the exercises, we recommend that you gather the following information and have it available as a resource:

- Current position descriptions for eligibility and clerical staff, including knowledge, skills and abilities required, if available
- Current organizational charts and staffing levels
- Current staffing performance reports and tools — such as annual review forms
- Current training curriculum outline, training plan, and evaluation data, if available
- High-level picture of new service delivery model for health and human services
- Input from eligibility and clerical field staff

Exercise 1

Assess your current staffing model

The goal of this exercise is to help you gather data that will help paint a picture of your current staffing model so you can more easily identify components that will need to change or evolve to prepare for the changes in Medicaid and human services eligibility.

This exercise is intended to be completed prior to convening a group of experts and stakeholders to develop your staff readiness plan. It can be completed by the project manager and one or more people who have subject matter expertise as a "homework" assignment, or the project manager may choose to convene a pre-meeting with a small group of experts in HR and training to complete the exercise together.

Questions on the Current Staffing Model

Key Questions: *What positions and/or classifications are currently being used to staff your eligibility work (e.g., clerical, eligibility specialists, generalists, specialized by program, combination, etc.)?*

Key Discussion Points:

Key Questions: *What are the job duties for each classification? What are the associated competencies needed for those job duties?*

Key Discussion Points:

Key Questions: *What are the staffing levels for those positions? What is the average caseload per worker?*

Key Discussion Points:

Key Questions: *Are those levels sufficient to meet your performance standards or goals? On average, how many tasks are staff able to complete per day/week/month?*

Key Discussion Points:

Key Questions: *Do you have contracted staff? If so, how are responsibilities divided between in-house and contracted staff?*

Key Discussion Points:

Key Questions: *How are staff positions funded (e.g., funding sources, cost allocation)?*

Key Discussion Points:

Key Questions: *How are staff trained on program changes now?*

Key Discussion Points:

Key Questions: *Who provides the training?*

Key Discussion Points:

Key Questions: *If you have staff who specialize in one program (such as CHIP, Medicaid, or SNAP), do they receive any training in other programs?*

Key Discussion Points:

Key Questions: *What are your current performance expectations for staff (if any)?*

Key Discussion Points:

Key Questions: *How is worker performance monitored? How often is performance reviewed? What elements of performance are monitored? Who is responsible for completing the review process?*

Key Discussion Points:

Questions on Current Responsibilities and Training of Supervisors

Key Questions: *Which classifications or positions currently have responsibility to supervise eligibility staff? Do offices use team leaders and how does this role differ from that of a supervisor?*

Key Discussion Points:

Key Questions: *What are the staffing levels for those positions? Are those levels sufficient to support staff and meet performance expectations?*

Key Discussion Points:

Key Questions: *What tools are supervisors using to manage staff performance?*

Key Discussion Points:

Key Questions: *How well do supervisors manage change now? Are they generally fatigued or energized by change?*

Key Discussion Points:

Key Questions: *What training is provided for supervisors now?*

Key Discussion Points:

Key Questions: *Are supervisors cross-trained in all programs?*

Key Discussion Points:

Exercise 2

Host a staff readiness planning meeting

The goal of this exercise is to guide a discussion about the design of your new staffing model with a workgroup of stakeholders. The outcome of the meeting will be a set of answers to important questions that will help you complete other readiness tasks, like editing position descriptions, developing new performance expectations, and identifying training needs.

Begin the meeting by reviewing the results of Exercise 1 where you answered questions about your current staffing model. You may also want to review the high-level design of your future service delivery model. Then use the questions below to facilitate a conversation with workgroup members about options for your future staffing model.

Discussion Questions on Developing the Future Model

Key Questions: *What eligibility worker classifications do you plan to use (e.g., clerical, eligibility specialists, generalists, specialized by program, combination, etc.)?*

Key Discussion Points:

Key Questions: *What are the job duties of the redefined classifications? Are they changed from current duties? If so, how are they changed?*

Key Discussion Points:

Key Questions: *How many staff will be needed to ensure access to programs and compliance with performance standards and benchmarks?*

Key Discussion Points:

Key Questions: *What are target staffing levels for those positions?*

Key Discussion Points:

Key Questions: *What is the target average caseload per worker in a case management model?*

Key Discussion Points:

Key Questions: *In a task-based work model, what productivity measures will you use? What are your targets?*

Key Discussion Points:

Key Questions: *How will productivity expectations change over time as the process gets more efficient?*

Key Discussion Points:

Key Questions: *Is there a need for contracted staff? If so, how will responsibilities be divided between agency and contracted staff?*

Key Discussion Points:

Key Questions: *Where will staff be located?*

Key Discussion Points:

Key Questions: *How will staff be funded (e.g. funding sources, cost allocation)?*

Key Discussion Points:

Key Questions: *What will be the performance expectations for staff? How will performance be monitored?*

Key Discussion Points:

Discussion Questions on Responsibilities and Training of Supervisors in the Future Model

Key Questions: *Which classifications or positions will be responsible for supervising eligibility staff?*

Key Discussion Points:

Key Questions: *What will supervisor job duties include in the future?*

Key Discussion Points:

Key Questions: *What is the ideal supervisor-to-worker ratio? Is that realistic, especially during transition?*

Key Discussion Points:

Key Questions: *What is the plan to prepare supervisors to help staff cope with change?*

Key Discussion Points:

Key Questions: *What training will be provided to supervisors?*

Key Discussion Points:

Key Questions: *What tools will be provided to help supervisors monitor staff performance?*

Key Discussion Points:

Exercise 3

Outline a training plan for staff and supervisors

It can be tempting to plan for training related to major changes as a single event, e.g., a two-part training that will review new eligibility changes and the associated computer systems skills course to support the change. However, it is wise to plan for training as an ongoing business function, which involves thinking about how new staff will be trained in the future, how refresher training will be provided for current staff, and how quality improvement will be addressed through ongoing training. The timing of training is also important to consider. Technical training delivered too early isn't effective because staff forget what they've learned if they aren't able to practice soon after. Soft skills training should be delivered first so staff better understand why their jobs are changing and are prepared for technical training.

The goal of this exercise is to help you develop an outline of a training plan that will prepare and support staff and supervisors to transition to your new staffing model. This is not a training plan, but will help a workgroup of training, operations, and policy experts make high-level decisions that can later be developed into an agency training plan. Completing the table below could be accomplished in a two- or three-hour workgroup meeting. It would be helpful to have a copy of the current staff training plan (if one exists) as a reference.

Outline of Training Plan

Position/ Classification	Skills Needed	Priority (High, Medium, Low)	Timeline (Date Needed)	Delivery Method	Resource (In-House, Contracted)
Ex: Intake eligibility staff	Multi-program eligibility policies	High	Oct 2013	Classroom	Agency training unit
	IT systems training	High	Dec 2013	Classroom	Systems vendor
	Effective Interviewing	Medium	Mar 2014	Workshop with practice	University X
	Dealing with difficult people	Low	Jun 2014	Online	Consultant Y
Ex: Supervisors	Multi-program eligibility policies	High	Aug 2013	Classroom	Agency training unit
	IT systems training	High	Dec 2013	Classroom	Systems vendor
	Effective delegation	Medium	Jan 2014	Classroom	Department of Personnel training
	Using data to monitor performance	Medium	Jun 2014	Online with practice	Consultant X
	Change management	Medium	Jul 2013	Workshop with peer groups	Consultant X

Resources

Exchange Eligibility Final Rule 45 CFR Parts 155, 156, and 157 "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," U.S. Department of Health and Human Services, March 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

Medicaid Eligibility Final Rule 42 CFR Parts 431, 433, 435, and 457 "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010," U.S. Department of Health and Human Services, March 16, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

Principles of Adult Learning: http://wcwpds.wisc.edu/mandatedreporter/adult_learning.pdf.

Project Management and Communications

Background

Each state is approaching the Affordable Care Act (ACA) governance and planning somewhat differently, so project management and communications may be handled quite differently depending on the approach. The planning associated with preparing eligibility and enrollment policies and systems may have been folded into the work of a pre-existing workgroup tasked with coordinating health and human services eligibility policies. Other states are creating a new organization to manage ACA readiness and the HIX post-implementation. Others have just begun planning for ACA and haven't yet decided how they will manage implementation. Regardless of how a state structures its planning and implementation effort, a foundation for success will be ensuring that the state's workgroups have a clear understanding of their mission — for example through a project charter — and a plan for how to communicate internally and externally about the project team's role and how its work relates to the agency's overall efforts. This is especially important if more than one agency is involved in eligibility and enrollment in the state.

A project charter contemplates the urgency for change, the team structure, the vision for change, and empowering the project team. This is important because it creates transparency and accountability for their mission and why it is important to the goals of the agency.

A solid communications plan will help ensure that staff throughout your agency or agencies know the purpose of the change the project team is undertaking. Internal communications about a project fall into two broad topic areas:

1. **How the change affects the organizations involved.** This includes explaining where the organization is today and why change is necessary; offering a broad overview of how the organization will transition to a new service delivery model, including what will change and when the changes will occur; presenting the benefits to the agency, providers, and clients as a result of the change; and letting people know that the change is real and that it will happen.

2. **How the change affects employees.** This involves discussing the details of changing roles and/or how employees' day-to-day activities will be affected (e.g., answering the question: why should I care about this?); letting employees know that resources and training opportunities will be provided to give them the knowledge and skills they need to succeed in the new model; soliciting feedback, ideas, and input about the change from staff; planning to periodically update staff on the status of the project; and letting staff know where they can go for more information.

It is important to communicate the right information to the right people at the right time. If messages are communicated too soon, staff will forget critical information. If information is communicated too late, there is a risk staff will not be ready for the changes in their roles and responsibilities.

Best Methods for Communicating Change

Research done on large-scale projects — like the transformational changes required to implement the Medicaid provisions of the ACA — shows that employees prefer to receive information about the project vision and urgency for change from executive managers. The employees' immediate supervisors or managers are the key senders of messages that pertain to the individual and work unit-level experience of change. The two most effective communication methods for communicating change to employees are:

1. One-to-one or face-to-face discussions that are honest, straightforward, and offer details of the change on a personal level. Employees prefer personal interaction over reading information.
2. Small group meetings to share information, brainstorm ideas, and discuss new or changed work processes.

The purpose of the Project Management and Communications module is to help states successfully initiate a project to redesign their service delivery model in preparation for the Medicaid eligibility and enrollment changes in the ACA. The tools and templates included in this module assume that the project has a sponsor(s) who is committed to approaching the planning process in a holistic and integrated way.

Goals

This module of the toolkit will help your team:

- Use solid project management principles in your project planning efforts.
- Create an outline of a project plan with answers to the fundamental questions about the structure and principles of your project, including roles and responsibilities of team members, a project calendar, and an issue resolution process.
- Create an outline of a communication plan that identifies key themes, target audiences, campaign messages, delivery methods, and timing.

Tools

This module includes the following tools:

1. **Exercise 1:** Initiate a project charter
2. **Exercise 2:** Build a communication plan outline
3. **Wrap-Up and Next Steps:** Prepare for implementation of project management and communications plans

How to Complete this Module

This module is intended to be completed by one or two people — typically the project sponsor and project manager — at the inception of the project, prior to chartering workgroups. The project charter exercise does not require broad stakeholder input, but once it has been signed by the project sponsor it can be shared with potential workgroup members as a way to understand the project goals and objectives.

You may want to create a small workgroup to help develop the communications plan. If you have a communication expert in your organization, be sure to tap their expertise.

Exercise 1

Initiate a project charter

The goal of this exercise is to help you answer the questions you'll need to address in order to manage the tasks associated with changing your Medicaid service delivery model and associated human services administrations. It is possible your state is already working with an IT systems vendor to build a state health insurance exchange (HIX) and/or to develop or upgrade your eligibility system(s). You may have multiple complex project plans to support those IT systems projects. They may include considerations for staff training, project-related communications, and issue resolution. The project charter envisioned here would not replace those more detailed plans, if they exist.

Rather, the project charter you will develop as part of this exercise is intended to be used by a project sponsor and a project manager who wish to initiate a project plan that integrates the types of tasks required to transform an eligibility and enrollment system for health and human services. Think of it as an "umbrella" plan that aids different groups of people working on simultaneous changes to better communicate and coordinate on important points for integration.

In order to complete a project charter, you will need to assess (1) what work units in your organization will need to be involved to ensure a successful project, and (2) whether the agencies involved have established procedures for approving key decisions and removing barriers. For example, in most states implementing a new automated system the IT Division needs to be involved in the daily operations of the project, but there may also be an IT oversight committee which must approve any new project – both to validate the benefits of the project and the availability of funding. A project charter would define the role of that oversight committee and the types of decisions and issues that should come before the committee for approval. If ACA readiness in your state will involve creating new staff positions, then the HR office will need to be involved, and their role would be defined in the charter. If the project involves an outreach campaign, then the public affairs office would need to be involved and their role would also be defined in the charter.

The series of questions below can be used to guide a conversation between a project sponsor and a project manager about the guiding principles of the charter. The project manager can then take the answers and flesh them out in a draft project charter using the Project Charter Template in Appendix 6.1.

Project Charter Purpose

Describe the purpose of the charter and the intended audience.

Key Questions	Key Decisions	Next Steps
What is the name of the project?		
Who is the managing agency or agencies?		
What is the purpose of the charter?		
Who is the intended audience for the charter? What group is being "chartered"?		
What is the charter intended to prevent or encourage?		

Project Objective

Identify the project objectives and how they relate to the overall goals for the organization(s) involved.

Key Questions	Key Decisions	Next Steps
What are you hoping to accomplish in this project?		
Who will benefit from completion of the project? How will they benefit?		
What are the strategic goals of the organization?		
How do the project objectives support these goals?		

Project Scope

Provide a high-level description of the assumptions related to scope and constraints. The project plan will include a more detailed description of the tasks associated with the project.

Key Questions	Key Decisions	Next Steps
What types of tasks are included in the scope of this project?		
What assumptions have been made about resources needed to support the scope?		
Are there any constraints on the scope, like time, budget, or human resources?		

Project Authority

It's important for project sponsors to have an appropriate level of authority over funding, staffing, and program decisions for project success. Describe who is sponsoring the project and the role they will play.

Key Questions	Key Decisions	Next Steps
Who is the project sponsor?		
What will their role be in overseeing the project?		
Who should approve and sign the project charter?		

Roles and Responsibilities

Describe the overall structure of the core project team and their roles and responsibilities in the project.

Roles	Project Responsibilities	Contact Information for Representatives
Project Manager		
Steering Committee		
Stakeholders		

Expected Outcomes and Success Criteria

Describe how the project team will know they are on the right track and what success criteria the steering committee will use to evaluate whether the project is on track. Including expected completion dates for the major milestones will help to track progress. A more detailed project timeline will be developed in your project plan.

Expected Outcome	Success Criteria	Expected Completion Date
Example: **1.** Implement new verification policies and processes to support Medicaid ACA rollout.	• Medicaid verification policies are in compliance with the new ACA rules. • Verification processes for Medicaid and SNAP have been streamlined. • Job aids for eligibility staff have been created.	• Medicaid policies adopted by January 2014. • Process improvements implemented by 2014. • Job aids ready for staff training in October 2013.
2.		
3.		
4.		

Exercise 2

Build a communication plan outline

This exercise is intended to be used by a project manager and a core project team who wish to have an outlined schedule of when, how, to whom, and how often communication can be expected by project stakeholders. The outline will aid different groups of people working on simultaneous changes to better communicate and coordinate on important points for integration. The following key questions will help you complete the communication plan template available in Appendix 6.2.

Discussion Questions on Developing a Communications Plan

Key Question: *Who are the audiences or stakeholders that will be covered by the plan?*

Key Decisions:

Decisions Pending:

Key Questions: *What are the communication themes of this project? (Goals, objectives, and values)*
What are the key messages about those themes?

Key Decisions:

Decisions Pending:

Key Questions: *What types of communications channels have been used in the past? Were they successful? What new channels might need to be created?*

Key Decisions:

Decisions Pending:

Key Questions: *When does communication need to begin? When will it end?*

Key Decisions:

Decisions Pending:

Key Question: *Who will be responsible for updating and managing the communications plan?*

Key Decisions:

Decisions Pending:

Key Questions: *Who will help to implement the plan (resources)? What other types of resources will be needed?*

Key Decisions:

Decisions Pending:

Wrap-Up and Next Steps

Prepare for implementation of project management and communications plans

By now your core project team should have a common understanding of the importance of project management and communications and should have identified next steps that need to be taken to develop a project management and communications plan. We recommend the project manager complete the following next steps:

- Identify potential workgroup members that will be needed for subsequent sections of this toolkit;
- Identify additional resources needed to help with project management and communications;
- Begin developing basic communications collateral (e.g., a one-page project description to be shared with potential workgroup members; and
- Schedule project management and steering committee meetings.

Resources

The Roots of Agile Project Management, by Rick Freedman, Tech Republic, June 16, 2009, http://www.techrepublic.com/blog/tech-manager/the-roots-of-agile-project-management/1491.

Project Management Institute website for multiple articles and resources, http://www.pmi.org/.

15 Tips for Effective Communications Planning, by Putnam-Walkerly, Philanthropy411 Blog, May 24, 2011, http://philanthropy411.wordpress.com/2011/05/24/effective-comm-planning/.

Appendix 6.1: Project Charter Template

A. General Information

Information to be provided in this section gives a specific name to the project as well as pertinent information about the personnel involved.

Project Name:		**Date:**	
Sponsoring Agency(ies):		**Modification Date:**	
Charter prepared by:			

B. Project Purpose

This section communicates the purpose of the project and the charter that is being established.

C. Project Objective

This section defines the objectives of the project as they relate to the goals and objectives of the organization. Note: Projects are full of uncertainty. As such, it is advisable as part of this charter to develop an initial risk assessment to identify, quantify, and establish mitigation responses to high-level risks that could adversely affect the outcome of the project.

The project will support the following organization strategic goals. For each goal, project objectives are identified. The project plan developed as a result of this project charter will:

- Develop a project performance measurement plan to measure performance against these objectives.
- Provide a project performance report to document the results. The external oversight committee must approve the project performance measurement plan.)

Agency Goals	Project Objectives

D. Project Scope

The level of detail in this section should be sufficient to allow for detailed scope development in the project plan. A more detailed description of the project scope will be developed in the planning phase. The charter should assume project scope will change over time as the project and environment evolve. Be sure to include current assumptions about time, human resources, and budget constraints.

E. Project Authority

This section describes the authority of the individual or organization initiating the project, limitations or initial checkpoint of the authorization, management oversight over the project, and the authority of the Project Manager.

Authorization

This section ensures that the project initiator has the authority to commit the appropriate resources within the organization.

This Project Charter has been initiated by (project sponsor) and authorizes the expenditure of planning resources to complete this project charter as a first checkpoint for the project.

F. Roles and Responsibilities

This section discusses the overall structure of the project organization and roles and responsibilities throughout the project phases. Note: as an addendum to this sub-section, it may be advisable to develop a responsibility matrix. The matrix lays out the major activities in the project and the key stakeholder groups. It also provides a good example of showing cross-functional/organizational interaction.

Project Manager

This section explicitly names the project manager and may define his or her role and responsibility over the project.

Identify the Project Manager, his/her expressed authority, his/her performance expectations and approach, and his/her reporting relationship to the project sponsor and steering committee.

Oversight (Steering) Committee

This section describes the role of an oversight or steering committee in supporting the project manager and making decisions. It should describe the stakeholder groups that are represented on the steering committee and their role in the committee.

List Oversight Committee members and contact information.

Committee Member Name	Organization	Contact Information

G. Expected Outcomes and Success Criteria

This section describes key outcomes expected and the criteria the project team will use to determine if they have achieved their objectives.

Project Outcome	Criteria to Determine Success
Example: ***Seamless service delivery system that connects newly eligible Medicaid beneficiaries to human services programs.***	• Implementation of integrated online application for benefits. • Proportion of Medicaid recipients who receive SNAP benefits within 60 days of Medicaid eligibility determination. • No Wrong Door referral procedures developed and implemented with Community Based Organizations and providers.

H. Signatures

By signing this document you agree to this as the formal Charter statement to begin work on the project described within, and commitment of the necessary resources.

Name/Title	Signature	Date

Appendix 6.2: Communications Plan Template

AGENCY NAME
PROJECT NAME
[project ID #]

COMMUNICATIONS PLAN
Project Manager

Date
Version:

Table of Contents

Context and Project Background

As you have learned in the Project Management and Communications module, a solid communications plan will help ensure that your staff knows the purpose of the intended changes. Developing a plan usually starts by working with your core project team to create a mental picture of what will be different after the project is completed. Remember, the more detailed this mental picture is, the easier it will be for people to support the change.

A communications plan also helps to make sure that everyone has a role to play in making the changes that will be required for the new Medicaid/CHIP and human services delivery model. People participate when they feel they are making a genuine contribution to the success of the change, even if their role is simply to raise awareness about the project vision and goals.

In this section, fill in a summary of the project with which this communication plan is associated. List the relevant schedules and milestones here. Also, include information such as how risks and issues are communicated, the budget as it affects the communications plan, and key partners in planning the project.

You also will want to include information such as competitors, media coverage, and political climate if any of these factors apply to your project.

This section should be concise. Just enough information will be covered here to get the point across.

Stakeholder Analysis

Stakeholders play a critical role in the eventual success of any project, as they become actors in the new service delivery model. Two key components of modern methods of project management focus on stakeholder communications, the first focused more on internal communications and the second more on external:

- Getting project stakeholders to feel individually responsible for the work, but also feeling they are a part of a team of individuals that is collectively accountable for project outcomes; and
- Creating conditions and mechanisms to ensure that all project stakeholders have the same understanding of the goals and desired outcomes, so they are on the same page as the project and the environment evolves over time.

A good place to start is an evaluation of your internal and external stakeholders. Use the following table to capture the results of your stakeholder analysis. In the table, stakeholder names could be individuals or groups of people. This section should be detailed and should describe how you gathered the information to complete the analysis.

Table 1. Stakeholder Evaluation

	Impact of Project /Change on	Stakeholder Location	Preferred Method of Communication	Deadline to Initiate Communication
1. Stakeholder Name (insert)				
2. Stakeholder Name (insert)				
3. Stakeholder Name (insert)				
4. Stakeholder Name (insert)				

Communication Plan

Communication Objectives

In this section, you will want to list and detail all the objectives of your communication plan.

Key Question: *What are your communication objectives?*

Notes:

Key Question: *Do you want to increase collaboration?*

Notes:

Key Question: *How will stakeholders be kept informed?*

Notes:

Themes and Key Messages

This section is where you identify the project themes and key messages that all communications should adhere to. Include the goals of project and the values of project management (e.g., "The primary goal of this project is to make our business processes streamlined for easier accessibility by clients and improved efficiency for staff." Several key messages could be developed around that one theme.)

Communications Strategy

A well-planned project has a well-planned communication strategy. The following are examples of different types of communication strategies.

Regular Communication

Here, you will include information about how day-to-day communications will happen, primarily with internal stakeholders. Information in this section should include how to update status of tasks, communicate issues, and identify meeting agenda items. Anything that is important for the functioning of your project should be included here. The following table is an example of how you could identify and track regular communications.

Table 2. Regular Communications

Communication	Purpose	Audience	Author	Communication Vehicle Location	Frequency
Monthly status report to agency executives	To keep senior agency leadership informed of the project's progress and key upcoming activities.	• Executive sponsors • Steering Committee • IT advisory groups	Project Manager	• E-mail to list • Posting on agency website	Monthly
Weekly schedule metrics	Monitor and report progress on scheduled tasks. Troubleshoot problem areas and solve or escalate issues as appropriate.	• Project management team • Steering Committee • Others, as appropriate	Project Manager	• E-mail to list • Posting on agency website • Steering Committee meetings	Weekly
Project team calendar	Keep project participants aware of key project dates and to help them manage their schedules. Maintain training calendars.	• All project participants (project management team, steering team, line staff, and supervisors	Project Coordinator	• Post in project folders	Update as needed

Event-driven Communication

Here you will identify one-time opportunities to communicate with stakeholders about project status. You may also want to consider providing presentations to special interest groups, doing periodic demos of IT tools, and conducting target presentations to specific groups of staff. These could also be tracked in the event-driven communication table.

The following table provides you with an idea of what your project timeline might look like; however, this piece of communication could be managed in myriad ways. How you decide to record and present the information is less important than having a clear communication plan to which the team is committed and a schedule that is both manageable and adhered to.

Table 3. Event-Driven Communication — Example

	June	July	August
Project Kickoff	**Task 1:** Initiation meeting to be held June 1, 2012.		
Pilots	**Task 1:** Notify offices X, Y, and Z that they will pilot same-day service (June 1). **Task 2:** Produce and distribute monthly update for all staff on pilot offices' progress and any related organizational changes (1st Wednesday of each month).	**Task 3:** Produce and distribute monthly update for all staff on pilot offices' progress and any related organizational changes (1st Wednesday of each month).	**Task 4:** Produce and distribute monthly update for all staff on pilot offices' progress and any related organizational changes (1st Wednesday of each month).
Training	**Task 1:** Announce training for call center staff (June 15).	**Task 2:** Announce mandatory all-staff training for new employment / income verification system (July 1).	**Task 3:** Send offer for staff to tour same day service offices (2nd Tuesday of August).
Technology Improvements		**Task 1:** Announcement to all staff that call center testing is complete (Date TBD).	

Risk and Issues Communication

In this section, you will include the plan on how to communicate when things go unexpectedly. Who needs to be informed? When? Where? How?

You may find the following template helpful in recognizing and detailing risks and addressing issues in your agency.

Issue	Impact Level	Decision/Action	Responsibility	Follow-Up Date

Budget

In this section you will discuss factors including the percentage of the project budget that will be directed toward facilitating communication and what to do in cases of budget overage.

You may find the following table helpful in making thoughtful decisions and clearly communicating about your project's budget.

1. Total Project Budget	$
2. Budget for Communications	$
3. Previously Reported Expenses (Total)	$
4. Previously Reported Expenses (Communications-Related Only)	$
5. Expenses this Quarter (Total)	$
6. Expenses this Quarter (Communications-Related Only)	$
7. Total Expenses to Date	$
8. Total Communications-Related Expenses to Date	$
9. Funds Remaining	$
10. Communications-Related Funds Remaining	$

Approval

DOCUMENT APPROVED BY: _____ ON _____