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In This Issue

Medicaid challenged to shed "gatekeeper" image, simplify enrollment

To become eligible for Medicaid, an individual might have to visit a welfare office in the middle of the day several times, for a face-to-face interview, and struggle with confusing paperwork in order to prove his or her income. That scenario, however, may soon become a thing of the past.

While Medicaid programs have typically adopted a "gatekeeper" approach to enrollment, a sea change is under way. Beginning in 2014, the Patient Protection and Affordable Care Act will require states to use a "no wrong door" approach. This ensures that individuals will be able to enroll in whatever kind of assistance they are eligible for, by going through the process once.

"If the process of enrollment is made more family-friendly, and more consumer-friendly, that will go a long way toward increasing participation," says **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC.

While the vast majority of states are only beginning to analyze the changes that will be needed, a handful of Medicaid programs already have made significant progress. "Two states that stand out are Massachusetts and Louisiana, from different aspects of the process,"

*See **Medicaid challenged** on page 2*

Ohio Medicaid's new claims system about to go live

Ohio Medicaid is set to go live in December 2010 with a new claims adjudication system. This is expected to result in significant savings for the program, says **Tracy Plouck**, Ohio's Medicaid director. "We're going to have a front-end claims editor, which we see as a benefit relative to where we are today," says Ms. Plouck.

The multiyear initiative started back in 2004. "We are now finishing the development process. We are moving into a robust period of testing on a number of different fronts," she says.

However, Ms. Plouck says that after talking with other Medicaid directors who have gone through conversions to other systems recently, she expects it will take about a year after going live to stabilize the system and achieve federal certifications. "So, any cost savings that would be realized would likely occur beyond that point," she says.

Fiscal Fitness: How States Cope

An enhanced Web portal will give providers more self-service functionality. "We will have less of a paper-based system. We see that as a great

*See **Fiscal Fitness** on page 3*

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Cover story

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says Mr. Dorn. "Since enactment of its 2006 reforms, and indeed before that, Massachusetts has done a great job streamlining enrollment. Louisiana has done a fabulous job streamlining retention."

Only one application

Massachusetts has reduced the percentage of residents without coverage to less than 3%. In addition to the individual mandate and the subsidies for coverage, Mr. Dorn says that other less well-known policies have contributed to this successful outcome.

For instance, multiple subsidy programs are integrated into a single system for applications and eligibility determination. One application form is used for Medicaid, the Children's Health Insurance Program, the state's Commonwealth Care subsidy program created in 2006, the state's program to reimburse hospitals and clinics for uncompensated care, and state-funded programs serving immigrant children.

As a consumer, you don't need to worry about which program to apply to. You just fill out the form, send it in, and are told which programs you qualify for. "The Medicaid agency determines eligibility for all these different programs, including those run by different agencies in the state government. So, that has helped greatly," says Mr. Dorn.

Massachusetts also uses data to establish eligibility whenever possible. This means that individuals don't need to complete any application form at all. For example, the state had a previous program for subsidizing hospital care. When data from the state pool showed that somebody qualified for the new Commonwealth Care subsidy, the person was automatically found eligible and didn't have to submit an application.

"About a year and a half after the program got under way, roughly one in four residents had their eligibility for subsidies granted automatically based on data, without any need to complete application forms," says Mr. Dorn.

Another thing that Massachusetts did to streamline enrollment was to engage a network of private agencies to complete applications on behalf of consumers.

"There is a long-standing system of state and foundation support for community-based organizations in Massachusetts," says Mr. Dorn. This helps educate local communities and also helps consumers fill out forms.

"The state also said to hospitals and clinics that they would get no money from the state indigent care funds for patients who did not complete the standard application form," says Mr. Dorn.

That led hospitals and health centers to hire staff to complete applications for consumers. More than half of all successful applications for subsidies were completed by community-based organizations or health care providers, rather than by consumers themselves.

"The vast majority of newly enrolled consumers did not have to fill out paperwork in Massachusetts. That was a very important factor in the state's dramatic progress in reducing the number of the uninsured," says Mr. Dorn.

In Louisiana, when a child on Medicaid comes up for renewal at the end of an eligibility period, the state first checks available data to see if the child qualifies automatically. If available data show a reasonable certainty of continued eligibility, the child is simply renewed. If the data do not resolve eligibility questions, the family is contacted for more

information and is encouraged to provide that information by phone.

"Only when all those measures fail is the family required to complete paperwork," says Mr. Dorn. "As a result, less than 1% of children have their coverage terminated for procedural reasons at the end of eligibility periods, which is an extraordinary accomplishment."

At the same time, the state is among the best in the country in its federal track record to prevent erroneous eligibility determinations. "So, Louisiana showed you can maximize coverage available to children and safeguard program integrity, by significantly streamlining enrollment and retention procedures," says Mr. Dorn.

Objective data

Concerns have been raised that if it's too easy to get onto Medicaid, this increases the likelihood for mistakes and fraud. "But, that is not necessarily so," says Mr. Dorn. "If you base eligibility on hard, objective data, rather than application forms, you simultaneously improve the accuracy of decisions and reduce the burden on consumers."

By using data to renew eligibility, Louisiana increased the percentage of eligible children who got health coverage and reduced the administrative cost of determining eligibility. "It also helped lead to some of the country's lowest error rates, as found by the federal government," notes Mr. Dorn.

"To the extent you can base eligibility on good, solid data, you are protecting yourself from program integrity problems while you are sparing consumers needless paperwork," says Mr. Dorn. "This means more of them complete the process and get coverage."

States are already using data for many things, such as the Income Eligibility Verification System (IEVS), where a sample of the population is checked using data from state workforce agencies, tax records, and other sources. "So, states are moving in this direction from a program integrity standpoint," says Mr. Dorn. "These are solvable problems, but it will take resources and it will take effort. People can't sit back and wait."

(See related stories on dramatic increases in Medicaid enrollment, p. 5, challenges posed by the "no wrong door" approach, p. 5, and Massachusetts' efforts to streamline eligibility, p. 7.)

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Fiscal Fitness

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efficiency from an administrative perspective, both for the provider community and for our state staff," says Ms. Plouck.

A consumer tracking system will be used for inquiries. "If a provider were to call five different folks in a number of months, we would have a record of interactions with that specific provider," says Ms. Plouck.

A smart prior authorization function is planned for 2011. This would autogenerate some requests for authorization for individuals for specific services, based on claims history and diagnosis codes. "So, that would be a provider efficiency, as well as a staff efficiency," says Ms. Plouck.

Ms. Plouck says that the system puts the state in a better position in terms of changes required by health care reform on the claims payment side. "It is a rules-based system, so hopefully we would have a reasonable level of flexibility to effect changes on the claims side," she says. "It's easier to effect changes than if you had to go in and actually hard code your legacy system."

While the system is going live later this year, the major impact of eligibility expansion won't occur until several years later. "So, we will have a period of time to get comfortable in our new environment," says Ms. Plouck. "We can plan for what changes need to be made in the system."

Plan for unanticipated impact

Ohio Medicaid's eligibility system is shared between the state and the counties. "Because the county has a direct interface with the consumer, it is a system that touches a number of our different programs, including Medicaid," says Ms. Plouck. "Speaking from Ohio's perspective, the eligibility system is much more of a concern to me. It is an aged legacy system, and there is more risk to effecting changes there."

Any potential impact to other programs must be considered with any changes made related to health care reform from an information technology (IT) perspective, including the coding of the system and any policy implications.

"We have to be very planful in our approach," says Ms. Plouck. "Our system is about 20 years old, so there is a lot of hard-coded logic. We will need to be very careful. We need to make sure we don't break anything in the system by making changes that will have any unanticipated impact anywhere else."

It is too early to say if the system will need to be replaced, says Ms. Plouck. One reason is that, currently, the federal government does not offer an enhanced match for eligibility systems work, as it does for claims adjudication systems.

"To the extent that any state is

contemplating a replacement or major upgrade, it would be at the regular match — not anything enhanced," says Ms. Plouck. "So, as we move forward in Ohio, we are going to be very deliberate about the extent of the changes that need to be made. We will then make a fiscal decision. Do we enhance what we have, or do we procure something new? We are not at the juncture where we are making that decision."

Even if the decision was made to procure something new, this would be a multiyear initiative, adds Ms. Plouck.

"We will need to assess the options from a technical perspective and make our decision, probably in the context of the next biennial budget," says Ms. Plouck. "We would need to know by that stage what our plan is going forward."

Currently, Ohio Medicaid is in the process of identifying specifics in the health care reform bill and comparing these to what the current programs contain. The next step is determining what decision points will be, going forward, for various factors. For example, the benefit package that will be available for the expansion population may end up being different from what a state Medicaid agency currently offers.

"So, there may be some policy decisions related to that," says Ms. Plouck. "Also, we know the eligibility process will be different, because there is a new eligibility methodology for some consumers. We need to be mindful of the technical changes that need to be made to our administrative code rules, to our IT systems, consumer notice, all kinds of details."

At the same time, there are different time frames for matching rates, and different federal reimbursement rates for different services and different populations. All of this must be considered. "As we work to quantify what this is going to mean in terms of future years, we will need to layer all these moving parts on top of each other. So that work is under way," says Ms. Plouck.

Possible fiscal opportunities

The state's current biennial budget bill, which is effective from July 1, 2009, through June 30, 2011, calls for the Medicaid program to cost-avoid about $2.5 billion dollars. Ms. Plouck says this will be done through a combination of reduction strategies and revenue augmentation.

"We have made some changes in provider assessment, for example, on the revenue side," says Ms. Plouck. "We really have been quite aggressive in our contributions to help balance the state budget. But we try to do it in a manner that protects consumer interests."

In February 2010, Ohio Medicaid carved out the pharmacy benefit from its managed care plans. However, plans are now expressing an interest in retaking control of the pharmacy benefit, now that changes to the Drug Rebate Equalization Act allow managed care organizations to achieve the same level of rebates as state agencies have been able to realize.

"What we've told the plans and stakeholders is that we really need to assess the overall fiscal impact of the rebate changes to the Medicaid program and examine what subsequent policy changes might mean," says Ms. Plouck. The fiscal impact of leaving it carved out, as opposed to putting it back in, is still being calculated.

"There are related policy implications as well," says Ms. Plouck. "For instance, we like the concept that we have a single formulary and single pharmaceutical authorization process for all of our Medicaid consumers in Ohio. If we carve back in managed care responsibility for pharmacy, that would certainly be a point of discussion with the plan."

Ohio Medicaid is also looking closely at how health care reform could help it to expand on its current quality initiatives involving hospitals. "There are some demonstration projects, some of which have specific funding identified and some of which do not, that may help to further those things. But at this point, we haven't set priorities around which ones we would actually pursue," says **Trish Martin**, Medicaid health reform project lead at Ohio's Department of Job and Family Services.

Growth was planned

Since Ohio is a state that tends to lag behind national recovery efforts, continued caseload growth in 2010 was anticipated. "And in fact, that is happening," says Ms. Plouck. "It's essentially where we anticipated it would be and relatively consistent with our expectations. So, we're not experiencing any budget shortfall at this point, because we planned for this."

For the first full year after the 2014 expansion, 540,000 individuals are expected to become newly enrolled in Ohio Medicaid because of the expansion to 133% of FPL, added to about 2 million current enrollees. "And, we expect to see almost the same number of folks coming through the door who would be eligible today but have not enrolled," says Ms. Plouck. "We are drawing on data from state-specific health surveys to develop some estimates in that area."

Ms. Martin says that the legislation is bringing lots of state entities together to plan across the board. "One of the things we are trying to get our arms around is the new modified adjusted gross income methodology," she says. "Today, our income eligibility process is really focused quite a bit on the makeup of the family. It's not just based on straight income eligibility. It's also based on other provisions."

If a person is determined not to be eligible post-expansion, it will need to be determined whether that person would have been eligible in the old process. "So, in essence, we're going to have two, maybe even three, processes going at the same time, Because we work with our county partners, our local job and family services entity, we're also going to have to train them on those processes as well," says Ms. Martin. "I'm not saying it's insurmountable, but it's going to be pretty complex."

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States face "tsunami" of Medicaid applications

States are facing a huge increase in Medicaid applications under the Patient Protection and Affordable Care Act, with the total number of recipients projected to grow more than 40%, according to the Congressional Budget Office. "If states continue the traditional welfare office strategies for taking and processing applications, I don't know how they will be able to cope with the tsunami of applications that is headed their way," says **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC.

Computerizing eligibility determination would allow states to do more with fewer administrative resources. "Massachusetts dramatically changed the way they handle eligibility. It was a major sea change in how they did business," says Mr. Dorn. "They moved out of local offices to a statewide office. They shifted away from a system based on caseworker discretion to one driven by computerized logic routines."

This allowed a doubling of caseload with less than a 10% increase in staff. "The question is whether 50 states and the District of Columbia are going to be able to make a similar change between now and 2014," says Mr. Dorn.

Complicating that question is the issue of what federal resources will be available for information technology investments related to eligibility. Traditionally, enhanced federal match for computers has been limited to claims processing, while computer upgrades related to eligibility benefit only from a Medicaid 50% match.

"My hope is that federal policymakers will find a way to get states the money they need to dramatically upgrade their eligibility systems," says Mr. Dorn. "Otherwise, it might be tough for states to cope with this new flood of applications."

How much money the federal government and states will each provide is an important question to resolve, says Mr. Dorn. However, he notes that Massachusetts reported large operational savings after an up-front investment in computerized systems, since it became much cheaper to process applications.

"My impression is that states are looking at these issues of modernizing public benefit programs, including health coverage, but also other programs too," says Mr. Dorn. "There is a lot of pressure on states to do more with less. Local social services offices have been overwhelmed during this economic downturn; lots of states have been looking at new ways of doing business."

This includes streamlining eligibility determination for a range of public benefits programs. "I think many states are much farther along on this than was the case a few years ago," says Mr. Dorn.

He notes that Massachusetts' new eligibility system was in effect for several years before the 2006 reform. "It takes time to work the kinks out," says Mr. Dorn. "Ideally, states will start looking at these issues within the next year or two. But that will depend on great support from the federal government, both financially and in terms of guidance."

Mr. Dorn adds that generally speaking, he is impressed with how the U.S. Department of Health and Human Services is handling the situation. "I've been impressed at how quickly they've been moving to implement this enormous law," he says.

He points to three different regulatory packages that have come out in just a few weeks' time frame on dependent coverage, small business tax credits, and Medicaid reduced benefits packages applicable to adults. "That said, there are some important remaining questions. When they get answered, I think that states will be on firmer ground in moving forward," says Mr. Dorn. ■

"No wrong door" poses these challenges for Medicaid

The Medicaid expansion and the availability of premium credits for people with incomes up to 400% of the poverty line mean that millions of uninsured people will be able to get help paying for health coverage. "But, people will not necessarily know which program is right for them and their families," says **Judy Solomon**, a senior fellow specializing in Medicaid and the Children's Health Insurance Program (CHIP) at the Washington, DC-based Center on Budget and Policy Priorities.

So that people applying for coverage do not have to figure this out on their own, the Patient Protection

and Affordable Care Act (PPACA) establishes a "no wrong door" policy for Medicaid, Children's Health Insurance Program (CHIP), and premium credits.

"The Secretary of [the U.S. Department of Health and Human Services] HHS will design a single, streamlined application for all three programs that states can use," says Ms. Solomon.

As much as possible, states will limit paperwork by verifying that applicants meet eligibility requirements, such as citizenship or legal immigrant status and income, by matching data available from Social Security and the Internal Revenue Service. Medicaid and CHIP programs will adopt the same definition of income as the health insurance exchanges, a new mechanism for consumers to purchase coverage created by PPACA, will use for the premium credits.

"Achieving simple, streamlined enrollment as envisioned by the health reform law does present challenges for both states and the federal government," says Ms. Solomon. Here are three:

• **The subsidies for coverage in the new state insurance exchanges will be delivered through tax credits**.

Eligibility and the amount of the tax credits will, in most cases, be determined based on prior-year tax returns. Eligibility for Medicaid and CHIP, in contrast, is generally based on a family's current income.

"The administration needs to develop rules to address these different approaches, so people don't fall through the cracks and fail to receive assistance for which they qualify," says Ms. Solomon.

For example, someone might present a prior-year tax return at the exchange and be told that he or she appears to qualify for Medicaid rather than a premium subsidy. "But that same person then could be denied Medicaid coverage, because his or her current income is too high," says Ms. Solomon.

• **States receive a much higher federal matching rate for services delivered to people who become eligible because of the health reform law's Medicaid expansion than for services delivered to other Medicaid beneficiaries.**

Therefore, states must establish methods of identifying new eligibles. "These methods should not require that each applicant is first processed using the new rules to determine eligibility and then processed under the old rules to determine which federal matching rate applies," says Ms. Solomon.

• **State budget shortfalls have resulted in layoffs and early retirements among state employees, including experienced Medicaid policy staff.**

Even though the coverage expansion does not begin until 2014, planning for system and policy changes, staff training, and other key tasks needs to begin as soon as possible.

"The federal government could help, both by getting early guidance to states on the changes in Medicaid's income rules and by developing online applications and data exchange systems that states could use," says Ms. Solomon.

Great potential

In terms of how HHS is going to interpret the health care reform legislation, there are still many unknowns. However, **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC, says "there is great potential to take these good practices in a small number of states and spread them throughout the country."

For example, the legislation says that HHS should develop a single application form for Medicaid, CHIP, and the new tax credits provided under reform. "In each state, the agencies that determine eligibility for these different subsidies need to develop a working relationship. Once consumers complete the application form, it is processed seamlessly. The consumer receives word of any subsidies for which he or she is eligible," says Mr. Dorn.

The redefinition of Medicaid and CHIP eligibility, based on modified adjusted gross income, could potentially make it much easier to determine eligibility than in the past. However, Mr. Dorn says there are concerns.

"We don't know how HHS will address the situation of changing family circumstances. Family income may change a lot, and we don't know how the issue of claiming enhanced federal matching payments will be addressed," says Mr. Dorn.

In the future, income will be the sole determining factor for eligibility for adults. However, whether the state claims standard match or substantially increased match depends on whether the adult would have qualified for Medicaid under state law in 2009.

"So, we don't know how much information states will have to gather about things like assets, which [were] relevant in 2009 but will no longer be relevant starting in 2014," says Mr. Dorn. "It seems to me there are other ways to go besides putting these questions on the application form. But all of this needs to be sorted out."

Another potential stumbling block is the fact that the legislation doesn't include much funding for community organizations to facilitate enrollment. "The bill says that exchanges need to have patient navigator contracts with various kinds of organizations. Among the functions is helping individuals enroll into coverage, but there are other functions as well," says Mr. Dorn.

Also, there is no federal funding past the health care information exchanges' first year of operation, so after that point the exchanges will need to raise money themselves. "I

worry that there will not be enough resources to help consumers enroll and maintain coverage," says Mr. Dorn. "Also missing from PPACA is funding for public education efforts to help the public understand available subsidies."

In contrast, Massachusetts laid the groundwork for increasing enrollment with a major public education effort. "Of course, we've got plenty of time between now and 2014. But we don't yet know if the federal policymakers will come up with the money for public education efforts," says Mr. Dorn.

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Massachusetts is front runner for eligibility streamlining

While many states are just beginning the process of evaluating ways to streamline the Medicaid eligibility process, Massachusetts did so a decade ago. That was when the state first looked into the possibility of developing an electronic application for Medicaid.

"Things accelerated during the 2002 to 2004 time frame, when we had a change in administration and there was a significant reorganization," says **Phil Poley**, chief operating officer for MassHealth.

For most of the 17 agencies which are part of the state's Executive Office of Health and Human Services, the majority of their beneficiaries are also Medicaid members. "So we decided to make Medicaid, in a sense, disappear as a state agency, and become part and parcel of the secretary's office, and have Medicaid administration happen, when appropriate, within these other agencies," says Mr. Poley.

That led to the development of the state's Virtual Gateway, a web-based portal for people to apply for a variety of services, including Medicaid. "There were legitimate concerns from applicants — and those who provide care to them — that we had too many doors, and it was confusing," says Mr. Poley. "It was also motivated by a belief that we would save money on our administrative costs."

Also, if providers were able to submit an application on behalf of a patient at the moment he or she arrived for care, many of those individuals would become eligible for Medicaid or another program. Thus, the uncompensated care pool funds would not have to be utilized for those cases.

When the Virtual Gateway first was made available in 2004, people were able to submit an application for several programs. Individuals now can apply for 11 different programs. On the health care side, people are applying for the health care safety net funds, Medicaid, and Commonwealth Care, the state's expansion program covering people at up to 300% of the Federal Poverty Level (FPL).

"What it doesn't do is put you into an eligibility or selection process if you are over 300% of the FPL," says Mr. Poley. "Those are people who are eligible for the Commonwealth Choice program, which is analogous to the exchanges. That is more typically your commercial products that are available." However, most individuals who apply do wind up being eligible for one of the subsidized programs.

Before the state's major health care reforms, a platform was already in place for online applications. After the 2006 implementation, the MassHealth application was simply adjusted to accommodate the questions that Commonwealth Care would need answered by applicants.

"So, in many ways, it was not a separate process we had to develop for applicants," says Mr. Poley. "It was one place — this is the application for benefits, period. We added the logos of all our three programs to all of our materials. It was clear to people that they were applying for all potential benefits through one front door."

Face-to-face contact for health benefits is no longer required, except for the Temporary Cash Assistance for Needy Families program. Currently, the breakdown of applications is about 60% electronic and 40% paper.

"Obviously, I'd like to see that ratio be much more electronic. Generally, it takes about 20 minutes to complete a paper application and only nine minutes to complete an application online in the virtual gateway," says Mr. Poley. "On the back end of things, our processing of online applications occurs much more quickly than paper applications."

Here are some factors that state Medicaid directors would do well to consider, says Mr. Poley, based on Massachusetts' experience:

• **People will need assistance with filling out applications.**

Mr. Poley says that the MassHealth Medical Benefit Request is "fairly lengthy and complicated." For this reason, individuals seeking health benefits are directed to sites where health care providers or staff from outreach organizations are available to assist in completing these.

"We have about 4,000 people in the state who have been trained to complete applications, and 240 health centers and hospitals where people can go to submit them," says Mr. Poley. "We have found that is a better way to get a cleaner, more accurate application on the first pass."

Making the application directly available to consumers is a possibility

for the future. "I think it would be great to simplify things to the point where we could obtain an application from a person online. But so far, we haven't seen a way that we think would be beneficial to anybody to do that," says Mr. Poley.

Very few applications come in without any assistance, and those that do typically have problems that need resolution. This means it takes longer for the person to get the benefits for which they're eligible.

"The application is well-liked by the provider community, and we don't pay providers to render this assistance. It's in their interest to assist people, since that is the way they get claims paid," says Mr. Poley.

• To meet the citizenship and identity requirement, an interface can be developed with the state's Registry of Vital Health Records and Statistics.

"If the applicant is born in Massachusetts and signs a release when they apply, the interface is activated," says Mr. Poley. "In layman's terms, we ask the database if there is a birth certificate, and the answer comes back yes or no." This means that a person no longer has to get a copy of his or her birth certificate and send it in.

MassHealth is currently in dialogue with the state's revenue department about the possibility of using income data for the eligibility and redetermination process, so applicants would no longer need to submit pay stubs to verify income.

"We already get data from them that tells us when people get new jobs, what their quarterly wages are. We use that for program integrity measures," says Mr. Poley. The next step would be to verify income eligibility, both for the initial application and the annual redetermination.

"Those are the sort of things that electronic means of transacting business give us the capability of doing," says Mr. Poley. "This makes it easier for consumers, providers, and ourselves — and saves money — to be quite honest. We spend a lot of time dealing with pieces of paper, and that costs money."

• The risk of fraud is probably decreased.

"We don't think this creates increased risk for fraud. We think if anything, it shuts the door on the risk of fraud," says Mr. Poley.

Since validity checks can be done with online applications, this makes the system more accurate. "If someone mistakenly skips an entry on the paper application, we then send them a letter, asking them to answer the question," says Mr. Poley. "Not only is it costing time and money for us, but it's preventing the person from getting the coverage they're eligible for."

Since applicants are face-to-face with a provider in a health care setting, concern about fraud is diminished. "The way we deal with fraud is maintaining a very good and active relationship with health care providers and other folks who see people who are applying for our benefits," says Mr. Poley.

Applicants aren't required to prove their residency, as some may be living with relatives and may not have a power bill or other documents typically used to prove residency. "That's certainly an avenue where a foreign national can come in seeking health care and not really be eligible for benefits," says Mr. Poley. "We deal with that type of thing through partnerships with Homeland Security, to close the door on folks who might come here seeking health care services they don't deserve."

• Information should be shared with providers and applicants.

Once a person is enrolled, the My Account page is made available to health care providers. This lists the members of the household, notices sent to the household, what individuals are eligible for, and demographic information. In March 2010, this was made available to members as well.

To verify the identity of the member, an online self-registration process is used. This is similar to the process used in the commercial sector, with the member asked to answer security questions.

However, this process is utilized only for existing clients, not new applicants. "Obviously, in the commercial world there are good examples of how to do that, and we are looking at those," says Mr. Poley. "But I think our application is at a level of complexity that it really would need to be simplified before we go to that."

• Changes should be piloted.

While individuals currently can apply for 11 programs online, in the early stages there were only four or five. "One of the big things that I would say is: 'Start small,'" says Mr. Poley. "We are very big here on piloting things before we put them out to the world all at once. That has been a very successful strategy."

For instance, when the My Account page was put up, it was first piloted through an organization that sees a lot of members, so that problems could be fixed before the larger community saw it.

• Things may take longer than expected.

It takes time to get through the various levels of legal and policy review that are required. "Don't think that since it takes X amount of days to build a website, that's how long it will take to put the application online. It's going to take you longer," says Mr. Poley.

• The production environment must be scaled and sized appropriately.

"You can't just throw up a website. You have to be ready to support that function in production, so if you take a bunch of traffic on this website, it's not going to grind to a halt," says Mr. Poley. "You have to have a help desk available to navi-

gate problems and all the rest of it."

• **The issue of households should be considered.**

Mr. Poley says that if the program were to redesign its eligibility processes, he would change the fact that Medicaid eligibility is determined at the household level. "This means that for the database at the core level of our eligibility system, the basic unit is households," he says. "And that can create problems."

For example, the My Account page is only accessible to the head of the household — the person who signed the application for benefits originally. This means that at the time the application was completed, that individual agreed to the terms and conditions.

"We were advised by our attorney that it would not be appropriate to present information to members of the household who did not sign that release," says Mr. Poley. "I don't know how to solve this problem yet. But if we dealt with people at the person level, even for just managing their data, that would probably be more effective." ■

CHIPRA is "platform" for enrollment changes

Beginning in 2014, individuals must be able to apply for and renew coverage for Medicaid, the Children's Health Insurance Program (CHIP), and tax credits for exchange coverage using a single application — and to do this online. States will utilize existing state and federal government databases to establish, verify, and update eligibility.

However, due to many of the options available in the Children's Health Insurance Program Reauthorization Act (CHIPRA), some states have already begun making those changes.

"Many of the strategies promoted by CHIPRA fall right in line with the administrative simplification and data-driven eligibility processes laid out as part of health reform," says **Beth Morrow**, a Brooklyn, NY-based staff attorney for The Children's Partnership, a child advocacy organization.

"CHIPRA helps states to build those practices for Medicaid and CHIP programs right now," says Ms. Morrow. "And they can do so in a manner that creates a platform for health reform enrollment systems."

Specifically, the Express Lane Eligibility provision in CHIPRA allows state Medicaid and CHIP agencies to base an eligibility or renewal determination on information provided in state tax returns or on the specific findings of other need-based programs.

Under section 2002 of the Patient Protection and Affordable Care Act, states are authorized to continue to use Express Lane Eligibility.

"CHIPRA also encourages states to construct administrative, paperless renewal processes, using available data to perform renewal without contacting the family," says Ms. Morrow. "Furthermore, CHIPRA helps states make these systems improvements by providing performance bonuses for a few more years."

Many states taking advantage

Although states are continuing to experience budget shortfalls, many continue to move forward with the simplifications and expansions made possible by CHIPRA.

"Somewhat surprisingly, given the economy and state budgets, many states are taking advantage of these options and are actively working to increase Medicaid enrollment," says **Jenny Sullivan**, a senior health policy analyst at Families USA in Washington, DC. "This is setting the stage for successful health reform implementation."

Because CHIP and Medicaid are so closely intertwined, many of the opportunities CHIPRA created are available in both programs. The Centers for Medicare & Medicaid Services (CMS) awarded $40 million in CHIPRA outreach and enrollment grants to agencies and organizations in 42 states and Washington, DC, in September 2009. Options include:

• **States can simplify the citizenship documentation requirement by conducting data matching with the Social Security Administration.**

"As of April 2010, nearly half of all states had begun or were in the testing stages of implementing the option to match Medicaid and CHIP applicant information with Social Security Administration databases to confirm citizenship," says Ms. Sullivan.

• **By implementing at least five of eight enrollment simplifications in both Medicaid (for children) and CHIP, states can qualify for performance bonuses.**

Nine states have implemented at least five enrollment simplifications in Medicaid and CHIP and met enrollment targets for children's Medicaid enrollment, qualifying these states for performance bonuses totaling $72.6 million.

• **Express lane eligibility can be used to streamline enrollment in both Medicaid and CHIP.**

"Three states have already implemented versions of express lane eligibility — Alabama, Louisiana, and New Jersey. Three others are actively pursuing the option," says Sullivan.

• **States have the opportunity**

to expand Medicaid and CHIP to legally residing immigrants previously prohibited from enrollment because of the five-year bar.

As of March 2010, 20 states have taken steps to cover legally residing immigrant children or pregnant women in the country for fewer than five years. "This includes two states that never covered this group prior to CHIPRA's enactment," says Ms. Sullivan.

Health reform makes simplifying and streamlining enrollment in Medicaid, CHIP, and tax credits for the health information exchanges (HIEs) "an imperative," says Ms. Sullivan. States' experiences with Medicaid and CHIP enrollment simplifications provide "rich information" on successful ways to improve enrollment and retention in the health reform context, she adds.

"It is critical that in the years between now and 2014, national, state, and local collaboration take place to encourage creation of the best possible enrollment systems," says Ms. Sullivan.

In order to redesign eligibility systems, states will need specific types of help, according to **Catherine Hess**, senior program director at Maximizing Enrollment for Kids in Washington, DC. "States are asking for this kind of support, so that each state does not have to invent its own wheels," she explains.

The hope is that CMS will work with states quickly to establish the parameters for new systems and assist with procurement and financing. "States have been clear that in order to have their systems ready for 2014, they need to start planning for them now," says Ms. Hess.

States also will need to examine how their Medicaid and welfare eligibility determinations interface. Another issue is whether county-based eligibility systems can meet the challenges and demands of efficiently enrolling millions more people.

"States have learned a lot about streamlining eligibility and enrollment, particularly through efforts to enroll children in CHIP, and Medicaid," says Ms. Hess. "We need to take the lessons further now, applying them systemwide."

The Robert Wood Johnson Foundation program Maximizing Enrollment for Kids is building on these lessons to make progress in improving state systems. "Health care reform now gives us a new set of tools to accelerate what we can do to simplify and modernize our policies and systems," says Ms. Hess.

In order for states to implement these changes, though, they need technical assistance and mechanisms to work with each other to problem-solve.

"The biggest challenge states face by far is that most of their eligibility systems are very old legacy systems that can barely handle the challenges of the current caseload, let alone the significant change coming in a reformed system," says Ms. Hess. "States lack the resources, dedicated staff, and time needed to update their systems properly."

The National Academy for State Health Policy has joined with the National Governors Association, the National Association of State Medicaid Directors, and the National Association of Insurance Commissioners to form a consortium to coordinate and develop assistance for states and work with federal agencies to support states in implementation.

Even with sufficient resources, staffing, and time to implement changes, states still need guidance on system requirements, which systems to select, and how to ensure that the systems will be able to communicate with other eligibility systems. "Although other challenges are significant, none surpasses the magnitude or importance of this one," says Ms. Hess.

Lan Nguyen, health policy coordinator for the Children's Alliance in Seattle, says that there are new opportunities for Washington state through CHIPRA. Prior to CHIPRA, state dollars funded coverage for children who did not meet the five-year bar requirement. However, Washington now receives federal matching funds to provide coverage for many of these children.

The federal performance bonus encourages states to implement procedures that are geared toward growing enrollment. "This is needed at a time like this when families have fewer options for affordable, comprehensive health coverage for kids," says Ms. Nguyen. "Washington received a federal performance bonus of $7.5 million in 2009 that has been vital in preserving our state's Apple Health for Kids program."

Federal health care reform represents a "sustained commitment" by the federal government for fiscal support of CHIP, as well as Maintenance of Effort requirements that eligibility not be reduced or additional barriers placed before families, says Ms. Nguyen.

To maximize the benefits under health care reform, Ms. Nguyen says these approaches are key for Washington state:

— Focus on activities that continue to enroll all children currently eligible for Apple Health for Kids.

— Develop strategies that maximize the use of data the state already holds to identify, enroll and renew coverage for eligible children, including Express Lane Eligibility.

— Identify ways to connect to children in other settings, such as those participating in free- and reduced-price meals in school.

— Streamline renewal processes, so that kids do not unnecessarily fall off of coverage at renewal time when there has been no change in eligibility level.

— Support outreach activities to identify currently eligible but unenrolled children.

In Washington, the upper-income

limit for Apple Health for Kids, the state Medicaid and CHIP program, is 300% FPL. "There will be more opportunities for other members of the family, including parents and caregivers, to obtain health coverage as a result of federal health care reform," says Ms. Nguyen. "This is vital, because we know that children are more likely to receive the care they need when their parents are insured."

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Will access problems become a thing of the past?

While research shows that Medicaid does a good job of facilitating access to care, compared to those without coverage, there are some concerns about access under the program. "This is especially true for specialty care," says **Rachel L. Garfield**, PhD, an assistant professor in the Department of Health Policy and Management at the University of Pittsburgh's Graduate School of Public Health.

Inequity in payment rates is one reason. Barriers to access are linked to low provider participation levels, which in turn are linked to relatively low reimbursement rates, as well as administrative burdens and geographic distribution of providers.

Only about 40% of physicians accept all new Medicaid patients, compared with 58% for Medicare patients, according to a September 2009 study from the Center for Studying Health System Change. The report, which surveyed more than 4,700 physicians, found that percentage decreased to 31% for family doctors and general practitioners, and 28% of all physicians didn't accept any new Medicaid patients at all.

"In some areas, there is a severe shortage of specialists who accept Medicaid patients," says Dr. Garfield. "For example, access to dental care has been a chronic challenge in Medicaid." According to a 2007 survey by the American Dental Association, fewer than 27% of dentists treated Medicaid-insured patients. A recent study by the Pennsylvania Medicaid Policy Center found that only 26% of practicing dentists in the state treated at least one Medicaid patient over the past year.

"Medicaid is a part of an evolving, quality-focused, patient-centric marketplace, with many changes happening simultaneously," says **Patricia MacTaggart**, a lead research scientist at George Washington University's Department of Health Policy in Washington, DC. "Access to insurance coverage is the first step. Access to appropriate care from the appropriate provider in the appropriate setting at the appropriate time is the next."

"Having a Medicaid insurance card does not in and of itself ensure access to care," noted **Joel Menges**, a managing director at The Lewin Group in Falls Church, VA. "Medicaid's payment rates to front-line providers have often been extremely low rates, relative to other insurance coverage programs."

Many physicians, dentists, and therapists either do not accept Medicaid patients at all or significantly limit the number of Medicaid patients they will treat. "For beneficiaries, this can make it challenging to find a provider who will treat them. It can also lead to prolonged waiting time for appointments," says Mr. Menges.

Provider cuts are often the first place that states look to trim Medicaid spending when they are faced with budget problems, notes Dr. Garfield.

"Those cuts can certainly exacerbate this problem by making providers less likely to accept new Medicaid patients, or leading them to limit the number of Medicaid patients they will see," says Dr. Garfield.

Kathy Kuhmerker, also a managing director at The Lewin Group, notes that because enhanced federal funding support is tied to states not making any changes in eligibility, provider rate reductions are one of the few options available to states to achieve cost-containment.

"Most state policymakers face by far the largest state-level budget deficits they've seen in their lifetimes," says Ms. Kuhmerker. "While states are reluctant to impose Medicaid provider rate cuts that can worsen provider participation levels and exacerbate access problems, they feel forced to do so anyway."

In terms of how health care reform will affect access, there are many unknowns. Two certainties, however, are that the population of Medicaid/CHIP enrollees will be growing, and that there are workforce limitations in primary care.

"Added to that, states are still in a difficult financial situation with limited options to balance their budgets," says Ms. MacTaggart.

Ms. MacTaggart says "the good news" is that the Patient Protection and Affordable Care Act increases Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014 starting Jan. 1, 2013.

States will receive 100% federal financing for the increased payment

rates. "The limitation of the language from a provider perspective is that it is only two years. The limitation from the state perspective is that the enhanced federal funding is only for two years," says Ms. MacTaggart. "This leaves both the state and providers questioning what happens at the end of two years."

For North Carolina and Washington, DC, there is no change, as they have already aligned with Medicare payments. For other states, the adjustment may be small or significant.

In order for the service delivery system to work for Medicaid, other publicly funded enrollees and privately funded enrollees, as the population to be served expands, the payments to providers must be adequate and the workforce issues must be addressed, says Ms. MacTaggart.

Dr. Garfield says that the increase in payment could address both the historical problem of low payment and participation, and the anticipated increase in participating providers needed to treat new Medicaid enrollees.

"The debate right now is whether the payment increase as structured in the law will fulfill these purposes," says Dr. Garfield. "It is targeted to primary care providers, so it does not address access to specialists." Also, it is specified only for 2013 and 2014, which is before the Medicaid expansion is implemented.

"Clearly the primary intention of the bill's massive Medicaid eligibility expansion is to facilitate access to care for those persons who are being made Medicaid-eligible," notes Ms. Kuhmerker.

The Lewin Group has estimated that more than 70% of the Medicaid expansion population will be comprised of persons who otherwise would have remained uninsured. "The increased payment rates for primary care services are another important access-enhancing piece of the reform bill," says Ms. Kuhmerker.

However, she adds that some Medicaid programs have already expressed skepticism that the two-year increase will be sufficient to convince currently non-participating providers to enroll in the program. Also, challenges accessing specialty care are likely to continue, given that states are unlikely to be able to increase those payment rates.

"On the more positive side, we estimate that the majority of new eligibles will be enrolled in managed care plans," says Ms. Kuhmerker. "These have historically been able to offer providers higher reimbursement rates than the fee-for-service program. This should also improve access to care."

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