Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
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Eligibility & Enrollment Systems: An Advocate's IT Toolkit

Overview Brief

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Glossary

Box 57144 3300 Whitehaven Street, N.W. Suite 5000 Washington, DC 20057
T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

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by Tricia Brooks and Julie Silas

Introduction

Even as states across the country continue to evaluate their options for implementing the Affordable Care Act (ACA), almost all states are moving (some quietly and behind-the-scenes) to take advantage of significant federal funding to modernize their information technology (IT) infrastructures in response to the new law.[1] The decisions being made now and in the months ahead will have far-reaching implications for the success of the ACA. If people feel welcomed and are encouraged to apply for health insurance through a sleek, simple-to-navigate website that easily connects them to coverage, it will have an enormous impact on their first impressions of health reform and, ultimately, on the ability of the law to meet its goal of bringing health coverage to almost everyone.

By allowing consumers to explore health coverage options; connect by voice or e-chat with someone who can provide more information; secure financial assistance to pay for coverage; and select a health plan based on the criteria that they care about; these new web-based systems will be the gateway to insurance in a new marketplace called the exchange. New consumer-friendly IT systems, linked to electronic sources of data to verify eligibility more efficiently, accurately, and timely than paper-driven processes, also hold the promise of revolutionizing the Medicaid eligibility and enrollment experience. These IT systems will often replace decades-old technology and create efficiencies by minimizing the paperwork burden on both consumers and eligibility workers in state, county, and local government offices; reducing processing delays and backlogs; improving client communications; and producing data to assess how well our health coverage programs are performing.

The reality for many consumer or policy groups, however, is that IT systems advocacy represents new and potentially daunting territory, particularly for those with limited IT technical knowledge. With this toolkit, we hope to provide some of the background information, key questions to ask about the system's functions and features, and strategies that advocates can use to ensure that IT systems are well-designed for consumers and promote the objectives of streamlined, simplified access to health coverage. The toolkit is designed to be useful for advocates in states that are operating their own exchanges, as well as those in states where a federally-facilitated exchange (FFE) will be operating alone or in a state/federal partnership model.

New web-based IT systems will serve as the storefront to private insurance options in an exchange and hold the promise of revolutionizing the Medicaid eligibility and enrollment experience.

Why get involved?

Even with already-full advocacy agendas and competing priorities, there are important reasons to get involved with the development of your state's IT systems. These systems are vitally im-

The IT infrastructure will create the primary gateway to coverage for millions, modernize outdated administrative procedures, carry out important policy decisions and shape consumer opinion of the ACA and public coverage.

portant to the success of health reform, serving as the primary gateway to coverage through the exchange and transforming eligibility and enrollment in Medicaid and the Children's Health Insurance Program (CHIP). Ensuring that consumers are well-served by these new web-based systems is a critical role for consumer groups and advocates who have fought long and hard to improve our public coverage programs. The IT infrastructure is vitally important to consumers because it will:

Create the primary gateway to coverage for millions. Thirty million or more people could move out of the ranks of the uninsured with full implementation of the ACA coverage options.[2] Roughly half are expected to purchase qualified health plans (QHPs) through an exchange, with many receiving advanced premium tax credits (APTCs) to subsidize premiums and other cost-sharing. The other half could gain coverage through an extension of Medicaid to lower income parents and other adults, along with the "welcome mat effect"–that is, the positive impact an expansion will have in increasing enrollment among people who are currently uninsured but eligible.[3] A majority of new enrollees are expected to sign up through online portals or websites, potentially with assistance from navigators or other consumer assisters. Ultimately, the effectiveness of these websites, and the underlying eligibility rules engine (the "brains" of the system that determines eligibility using data obtained from electronic sources), will be instrumental in determining whether the ACA meets its fundamental goal of streamlined, simplified access to coverage.

Modernize administrative procedures. For years, consumer advocates have worked with their states to streamline eligibility and enrollment procedures in Medicaid and CHIP, including:

- *Minimizing unnecessary paper verification;*
- *Decreasing the incidence of "lost" paperwork;*
- *Reducing random variation in how people are treated based on which eligibility worker is assigned to their case;*
- *Speeding up the rate at which applications and renewals are processed;*
- *Improving the quality, timeliness, and readability of notices;*
- *Facilitating better access to information for people with disabilities or Limited English Proficiency (LEP); and*
- *Promoting coordination across social service programs (e.g., Temporary Aid to Needy Families (TANF), the Supplementary Nutrition Assistance Program (SNAP), and Medicaid).*

In many instances, the new or updated systems will automate administrative tasks handled manually by eligibility workers today. The new IT systems are expected to supplement or even dramatically reduce the role of eligibility workers in gathering and reviewing paper verifications. If the IT systems run as intended, consumers will not need to supply a hard copy of recent pay stubs to establish their income. Instead, the IT system will look up someone's wages and sources of unearned income from federal and state databases to electronically verify income. The resulting reduction in processing paperwork will extend the capacity of assistance offices to handle the influx of new applicants and enrollees.

Carry out important policy decisions. Underneath the administrative processes, critical policy issues will be built into the system. For example: how will states define when information provided by the consumer and electronic data sources, although different, are "reasonably compatible"[4] and require no further review or explanation? Which data source will trump another? How will the system count a pregnant woman in the household size of her children for Medicaid? In some instances, these and many other policy questions arise during the system design phase and may be rushed to maintain the fast pace at which states and their vendors need to meet critical deadlines for IT deployment. Key policy decisions may not be considered in public but rather in small workgroups or advisory commit-

tees, thus it is critically important that consumer advocates call for the creation of, and participate in, IT stakeholder advisory workgroups.

Shape consumer opinion of the ACA and public coverage. For many Americans, their first experience with health reform will occur when they seek coverage. Beginning in October 2013, states must offer people the opportunity to sign up for any of the insurance affordability programs (Medicaid, CHIP, or subsidized coverage in an exchange) through an online process. If the experience is a positive one at the outset, it will go a long way toward shaping first impressions of the "real" ACA, not just the law as passed and endlessly discussed in the abstract by politicians and the media.

If both the systems and the underlying policies are done well, it will ease the paperwork burden people face when applying for or renewing coverage. If designed poorly, however, these types of automated systems could create new risks for consumers by denying them coverage based on outdated or inaccurate electronic data or by posing a risk for breaches in confidentiality.

What if my state will not be operating its own exchange? Will there still be a significant amount of work being done on IT systems?

States, including some reluctant to embrace the ACA, are moving forward to update and replace their current Medicaid IT systems, impelled by significantly enhanced federal financial assistance. No matter how a state plans to implement the coverage opportunities in the ACA, the law establishes new Medicaid eligibility rules based on tax-law definitions of modified adjusted gross income (MAGI) and household size, for most, but not all, Medicaid groups. It accelerates innovations pioneered by the states to verify eligibility electronically and streamline the renewal process. Equally important, consumers must be able to apply for and renew coverage online and have their eligibility and enrollment coordinated seamlessly between Medicaid, CHIP and the exchange.[5] Thus, all states will need to make some changes and add new functionality to their current Medicaid eligibility systems. The costs of enhancing, upgrading, or replacing Medicaid systems to meet new federal requirements are eligible for generous federal financial participation (FFP) at an enhanced rate (up to 90 percent for qualifying systems development and 75 percent for ongoing system maintenance and operating costs).[6]

Notably, certain cost-allocation rules for development costs of integrated systems that process eligibility for Medicaid and other public benefits, such as SNAP, are also temporarily waived. (Cost allocation still applies to sharing costs between Medicaid, CHIP and an exchange, and will also apply to ongoing system maintenance and operating costs for all programs.) Cost-allocation rules require that all programs using a shared system apportion the cost of development and maintenance by program. By suspending the cost-allocation requirements for a limited time, other programs can benefit from the enhanced Medicaid system functions and features without having to pay their full share of development costs. If the Medicaid system needs a feature and other programs benefit, the proportion (or cost-allocation) that the other program will have to pay is limited to the cost of integrating its specific requirements and sharing data between programs. For example, if Medicaid needs to develop an online application, the cost to SNAP to use the online application will be limited to the incremental costs for any additional requirements (such as supplemental questions) needed only by SNAP. Whether they are added in the beginning or at a later date, these add-on costs must be charged entirely to SNAP.[7]

The enhanced federal funding for Medicaid eligibility systems is time-limited, expiring at the end of 2015, when systems development costs will return to a 50 percent federal match. As a result, most states, at the very least, are taking advantage of this unprecedented opportunity to

If both the IT systems and the underlying policies are done well, it will ease the paperwork people face when accessing or keeping coverage and greatly improve program administrative efficiency.

States are being encouraged to adopt and adapt systems, or system components, from other states to expedite the IT development timeline for both the exchange and Medicaid.

upgrade, enhance, or replace their current Medicaid and CHIP eligibility and enrollment systems, even if they are not moving forward to establish a state-based exchange.

How do I get started?

There are a number of steps consumer advocates can take to get up-to-speed on state exchange and Medicaid IT activity and prepare to engage in the conversation.

Gather some of the basic information you will need for background to understand where your state is in process and what opportunities there are to engage. You can learn about what your state is planning by getting answers to a number of key questions:

Is your state setting up a state-based exchange, planning to use the FFE, or entering into a state/federal partnership?

At the one-year mark before exchanges need to be up and running, less than one third of the states were in the process of developing a state-based exchange.[8] As of November 16, 2012, states must declare which approach to an exchange they will take.[9] It is not clear whether additional states will have the time to develop or adapt a state-based exchange IT infrastructure to be ready on October 1, 2013 for open enrollment. Nonetheless, a number of states may make decisions later in 2012 to move forward with state-based exchanges even if it means starting with an FFE or partnership model initially due to time constraints.

States that are establishing state-based exchanges are responsible for developing their own exchange IT systems for eligibility and enrollment, which will be fully funded by federal exchange establishment grants through 2014. States that opt to work in partnership with the FFE or strictly use the FFE will rely on the Centers for Medicaid and Medicare Services (CMS) for most of the development for the exchange IT system. As noted above, these states must ensure that their Medicaid systems are updated to implement new Medicaid eligibility and verification rules and communicate smoothly and effectively with the FFE.

What is the scope of the IT work that the state has proposed or is undertaking? To what extent does the state plan to share components of the IT system between Medicaid, CHIP, and the exchange?

States have several options for moving toward a streamlined eligibility and enrollment system. Shared systems are more cost-effective to build and maintain, and also ensure consistency in how eligibility is determined across programs. States are also being encouraged to adopt and adapt systems, or system components, from other states to expedite the IT development timeline for both the exchange and Medicaid.[10] But not every state will be moving in this direction, so it is important to determine what approach your state will take.

For states building a state-based exchange, the high degree of interaction and seamlessness required between exchanges, Medicaid, and CHIP necessitates highly integrated systems. Guidance from CMS indicates that state agencies receiving federal funds to implement a state-based exchange and upgrade their Medicaid systems are expected to share an eligibility service. However, this does not necessarily mean that states will operate a single system, as there are different approaches states could take to fulfill this requirement.[11]

- A fully integrated IT infrastructure for both the state-based exchange and MAGI-based Medicaid. In this situation, the state will be operating one system that can be used simultaneously by the exchange, Medicaid and/or CHIP.
- A shared eligibility service for the state-based exchange and MAGI-based Medicaid groups. In this scenario, the exchange and Medicaid will share IT functions that produce a MAGI-based eligibility determination. The agencies may share other functions or services as

well, such as the consumer portal, interfaces to the federal data services hub or state verification sources, etc. They may also have different systems or components for managing some functions such as post-eligibility enrollment, case management, and renewal.

- **An IT infrastructure for eligibility and enrollment in a state-based exchange separate from Medicaid.** Given CMS' expectation that states minimally share a MAGI-based eligibility service, it is not clear how federal funding works if a state-based exchange intends to have an IT system entirely separate from Medicaid. Minimally, an electronic data interface will need to be established so that information can be transferred back and forth between the exchange and Medicaid to facilitate seamless, coordinated coverage, while the Medicaid system will need a make-over to comply with new eligibility, verification, and renewal rules.

For states using the FFE or creating a partnership model, the FFE will develop the exchange eligibility and enrollment system and there will need to be an electronic interface between the FFE and the state Medicaid system to exchange client records and other information. States have the choice to allow the FFE to make the final MAGI-based Medicaid eligibility determination or to assess Medicaid eligibility and refer applicants to Medicaid for the final determination. Regardless of which approach the state choses, Medicaid will still need to upgrade or replace its eligibility system to handle the new MAGI-based eligibility rules, as well as new electronic verification and streamlined renewal processes (which also apply to traditional Medicaid groups). Even if the FFE is making MAGI-based determinations on applications received through the exchange's consumer portal, the Medicaid agency may receive new applications directly and must also be able to process MAGI-based eligibility at renewal.

What about traditional Medicaid groups and other public programs? If the state is replacing its Medicaid system, what is the plan for continuing to administer traditional (non-MAGI) Medicaid groups, as well as other public assistance programs if currently managed in an integrated system?[12] Will these programs be maintained in separate systems, integrated into the new system design upfront, or phased into the new system over time? If traditional Medicaid eligibility (i.e., disability or long-term care services) is maintained outside the new system, even temporarily, a data interface will be needed to refer applicants screened as potentially eligible for other Medicaid categories. Data interfaces to other public programs can and should also be built to provide consumers with efficient access to other benefits if the systems are not fully integrated.

Even in states with a federally-facilitated exchange, Medicaid will still need to upgrade or replace its IT system to handle the new eligibility, verification and renewal requirements.

Federal Funding for Eligibility and Enrollment IT Systems

	Federal Funds	State Funds	Expiration
State-Based Exchange	100% through exchange establishment grants	0%	Last grant opportunity submission date October 15, 2014
Medicaid	90% federal financial participation for qualifying IT systems development (75% for ongoing maintenance and operating costs)	10% for qualifying systems (25% for ongoing maintenance and operating costs)	December 2015 for development costs
Other Public Programs	Through a temporary cost-allocation exception for development costs only, system features required by Medicaid can be shared by other programs. The other program will only be responsible for add-on costs (i.e., data interfaces) that are not required by Medicaid. These add-on costs may qualify for other federal matching funds according to each program's specific rules.		December 2015

Since all sources of enhanced federal funding for IT systems are time-limited, states must move quickly to take advantage of this unprecedented opportunity to modernize their IT infrastructure.

What steps has your state already taken to obtain funding for IT development?

CMS has made available a number of revenue streams to assist states in their efforts to upgrade, enhance, or replace their eligibility and enrollment IT systems.

All sources of enhanced IT funding are time-limited, thus it is important that states move quickly to take advantage of this unprecedented opportunity. Has your state:

- Applied or received approval for enhanced Medicaid federal matching funds for design, development, implementation, or enhancement of its Medicaid eligibility and enrollment system;
- Appropriated funds specifically for the state's share of Medicaid IT system development;
- Applied or received approval for IT funding as part of an establishment grant for developing a state-based exchange; and/or
- Applied or received approval for IT funding as part of an establishment grant for interfacing the state Medicaid/CHIP system with the FFE?

Where is your state in the design, specification, and vendor solicitation process?

Important policy and procedural decisions (for example, use of personal online accounts, web portals for navigators and assisters, approach to premium aggregation, etc.) are often embedded in vendor solicitations and/or the final contract. If your state has not yet issued a contract, there is still time to provide input on key issues. Has your state:

- Completed its IT Gap Analysis? – This analysis is an assessment of existing systems and what changes are needed to enable a streamlined eligibility and enrollment system that meets the requirements of the ACA.[13] An IT Gap Analysis is required to secure federal funding for IT.
- Issued a Request for Information (RFI) from potential vendors? States often issue RFIs to gather information that may be helpful in developing a request for proposals (RFP).
- Issued a Request for Proposals to prospective vendors? RFPs are a standard way for states to solicit competitive bids in procuring goods and services. Some states that had extensive system development projects underway prior to the ACA or approval of enhanced federal funding may be augmenting current contracts, rather than issuing RFPs.
- Selected a vendor or vendors? After reviewing proposals submitted through the RFP process, the next step is to select one or more vendors. States may choose to contract with a **project management firm** or a **systems integrator** that is responsible for coordinating the development and integration of different system components from multiple vendors. If so, this organization or team will play an important role in coordinating the IT project.
- Signed a vendor contract(s)? Between the selection and contracting process, there is the opportunity to negotiate various aspects of the contract from deliverables to price. If a state has neglected to include certain requirements in its RFP, there is still time to make changes if contracts have not been formally executed.
- Started the process of designing and building the IT system? At this phase in the project, activity accelerates and numerous policy and procedural decisions must be made. It's important that any deadlines include sufficient time for user-testing, including exchange and Medicaid staff, as well as consumers. Even at this stage, contracts can be amended to include modifications or additions to the system design.

Which agency is in charge of the IT development process?

In some situations, it will be obvious which agency is responsible for oversight of the IT development process. In other instances, a number of agencies may be collaborating to design a new or upgrade an existing IT system, leaving it less

clear who is in charge and ultimately accountable. Once you know which IT path your state is taking, the next set of issues will help you identify who your target audience is or in some cases, discover there is a problem having multiple agencies working together with no single entity having primary responsibility.

- Which agency or agencies are involved? If multiple agencies are involved, have they entered into a memorandum of understanding (MOU) that clearly defines each agency's role?
- Does the state have a separate project management team (either internal or contracted)?
- Has the state identified a lead agency or individual person responsible for reporting to HHS?
- Who has legal authority for oversight, monitoring, and accountability of the IT system and IT vendor?

Review the documents that are available, including early innovator or exchange establishment grant proposals, federal grant awards, blueprint proposals, IT Gap Analyses, state RFIs, RFPs, and vendor responses, IT vendor contracts, and other policy papers that include information about the IT system development. As you look through these documents, use the ten top issue areas (summarized below and detailed in separate fact sheets) to begin to identify and analyze what your state may be proposing. Some of the state IT documents can be lengthy and highly technical. By searching on key words, you may find relevant information more easily. Also look for sections of documents that describe the business requirements. Keep a running list of questions or important features that are not addressed in the information available.

For background information on federal funding opportunities and eligibility and enrollment systems requirements, see the resource list at the end of this brief. Additional documents have been made available to states through a CMS website called the Collaborative Application Lifecycle Management Tool (CALT). CALT is an online tool that creates a centralized repository for storing, collaborating on, and sharing deliverables and products (also called artifacts) from IT projects. Within the CALT, CMS has created the Medicaid State Collaborative Community to allow states the opportunity to leverage Medicaid information technology (IT) systems development projects and to submit products to the CALT for review and approval. Access to this website is limited to individuals approved by each state's access administrator.

What are the top issue areas for consumers?

When upgrading or designing a new IT system for health coverage programs, there are many technical decisions that impact the consumer experience. For example, states will have to decide early in the design process whether or not to build the capacity for individual online accounts that will provide an applicant with the ability to start, stop, and return to an application, receive e-notices, update their personal information, and more. These features facilitate consumer self-service and enhance administrative efficiency by maximizing the use of technology. If during the IT system development process the contract does not require the inclusion of online accounts, this important function may not be available (even in the future) and will limit consumers' ability to manage and maintain their health coverage via the web.

Early intervention from consumer advocates can go a long way to ensure that important policy decisions are made with consumers in mind. Below we have identified and summarized top issue areas for consumers in regard to the new or upgraded IT systems. Separate issue briefs on each of the ten areas include more detailed information and key questions advocates should think about as they review documents and communicate with policymakers.

Early and ongoing intervention from consumer advocates can go a long way to ensure that important policy decisions are made with consumers in mind.

A key function of the system will be to help consumers compare and make an informed choice of exchange qualified health plan. This same functionality could provide an efficient way for eligible families to select a Medicaid managed care plan.

Will the online application and consumer web-based services be easy-to-use? Technology is easier to use than ever before. Many, if not most, consumers today are accustomed to using web-based services for banking, making purchases, or booking travel. The IT system design for health care coverage under the ACA should make web-based access to coverage easy-to-use and accessible for consumers. Factors such as what the web-based services will look like to consumers (also called the customer portal or consumer/user interface), whether a person can browse anonymously on the website, and what languages the web applications will be translated into are critical. Consumer testing with different types of people expected to access the system will be paramount to assuring ease-of-use.

How will the system help consumers with special circumstances, such as immigrant families and children with divorced or absent parents? The website and online application should ensure that people with special circumstances understand how personal information will be used and how the programs work for their situation. For example, the manner in which the system asks questions of non-applicants, especially with regard to citizenship and social security numbers (SSN), matters. Additionally, helping families determine which parent should apply for a child's coverage when divorced parents have joint custody or parents live in different states will be an important consumer service. These and other circumstances present special situations that must be taken into consideration if the system is to function well for everyone.

How will the website facilitate access to personalized help from the call center, navigators, or other assisters? Even when using the most well designed website, consumers will have questions and some will need help maneuvering through the system to access coverage. Key factors in determining how well the IT design provides access to assistance include whether technology-enabled tools (such as e-chat) are built in to promote self-service; whether call center staff are able to view an application in progress; and how prominently the website enables consumers to search for and connect with navigators and other assisters who can meet their needs (i.e., language spoken, evening or weekend availability).

How will the IT system use electronic data sources to verify eligibility in real-time? Tapping electronic sources of data will provide states with more efficient, cost-effective, and accurate ways to verify eligibility. The goal is to be able to make an immediate – or real-time – eligibility decision as soon as the consumer has completed the application process. To achieve real-time eligibility and enrollment, the IT system will need to maximize the potential for verification of eligibility factors electronically, rather than through unnecessary paperwork, by interfacing with the federal data services hub and state sources of data. The system should also include back-up options to electronic verification, such as allowing applicants to upload a scanned image or picture of a paper document, if documentation is needed or if it provides more accurate information than electronic sources. While real-time eligibility may not be possible if a review of documentation is required, enabling electronic submission can lead to a faster eligibility decision.

How will the IT infrastructure coordinate coverage seamlessly between the exchange, Medicaid, and CHIP? To achieve the promise of health reform in the most streamlined and efficient manner, the relationship between public coverage programs and the exchange needs to be well coordinated. This is true whether the state is establishing its own exchange or relying on the FFE or partnership model. Vital to establishing seamless access to all of the insurance affordability programs are linkages between programs that are timely and invisible to consumers, as well as appropriate screening for (non-MAGI) Medicaid for people with disabilities or in need of long-term care services.

Will the web-based services help consumers compare, make an informed selection and enroll in a health plan of their choice? A key goal of the ACA is to provide consumers with comparative data to make an informed plan selection in the exchange. The ACA requires that IT systems enable consumers to compare, select, and enroll in a specific health plan as soon as eligibility is determined. This same functionality could provide a more streamlined way for eligible families to select Medicaid managed care plans. Key questions about whether the system makes it easy to enroll in a plan include: What kind of information will be available to consumers to help them compare and choose a plan that meets their needs in either the exchange or Medicaid? How will that information be presented? Will the system allow consumers to enroll and then pay premiums online so that the effective date of coverage is not delayed?

How will the system help people maintain and renew coverage? Maintaining continuous coverage is critical to improving health outcomes and measuring the quality of health care. The IT system should be designed to make it easy for eligible consumers to maintain and renew their health coverage. It will be important to assess how the system proposes to handle the reporting of changes in circumstances and how well the system is able to access and use data available electronically to renew coverage automatically with minimal intervention from the consumer.

How will the system protect the privacy and confidentiality of personal information? Assuring privacy and confidentiality of personal information is critically important to instill consumer confidence and trust in the system. Strong privacy and security protections need to be incorporated into the system on many levels. How will the system communicate its privacy protections to users? What steps can consumers take to correct or delete inaccurate information? What remedies are in place for breaches of security? These are key questions that states will need to address when deploying new systems.

Does the system provide clear information about grievance and appeal procedures and incorporate due process protections? Even if the IT system works the way it was intended, consumers will be denied coverage and want to question why they are not eligible for a specific program. The IT systems should provide clear information on grievance and appeal rights for consumers, as well as access to notices and information used to make eligibility and enrollment decisions. The systems should include clear pathways for consumers to initiate the grievance or appeals process and tools to exercise their due process rights.

What data will the system generate to evaluate program performance and consumer satisfaction? The IT system should collect and report data to evaluate program effectiveness and identify opportunities for improvement, and to detect and address health disparities. How the system tracks and reports vital measures of enrollment and retention, how the system promotes transparency so that information is accessible to consumers and stakeholders, and what mechanisms are in place to assess customer satisfaction with the eligibility and enrollment features of the website are important to determining whether the system supports a robust evaluation and ongoing improvement program.

The system should collect and report data to evaluate program effectiveness, detect health disparities, and identify opportunities for improvement.

How can consumer advocates get involved?

Once you have the basic information and/or have reviewed key documents about the status of your state's IT system development efforts, there are a number of additional steps that you can take to effectively advocate on behalf of consumers. Advocates can:

- Support your state agency requests for funding the state's share of IT costs. The minimal state share leverages significant federal funding that will result in many ad-

Technology will not only support consumer self-service and program evaluation, but also make government work better – more efficiently and cost-effectively.

ministrative efficiencies.

- Press for an open process that includes public access to key documents including RFIs or RFPs and vendor responses, system specifications, contract language or agreements with vendors, and Memorandum of Understanding (MOUs) or other agreements between agencies.
- Weigh in and express the consumer perspective by submitting comments to agencies and policymakers. If you have a public exchange board or open agency meetings, testify in support of components of the system that empower and protect consumers, and raise issues about areas where you are concerned.
- Call for or convene stakeholder IT workgroups that include consumers and advocates. Request stakeholder engagement in the development of the request for proposals and system specifications, as well as regular and ongoing information sharing as the system develops. Ask your state to provide access to CALT to stakeholders engaged in an advisory capacity.
- If possible, get some extra help from IT experts who can view the system design or requirements through a consumer lens. University systems, larger nonprofits, or health care organizations may have IT professionals who can provide technical assistance to advocates.
- If your state is adopting technology developed by another state, check with your advocacy colleagues in that state to identify if improvements are needed or additional features should be added.
- Insist on consumer focus groups and user testing of the IT system at multiple points during the development process. Also ask if you can observe the focus groups and provide feedback.

Summary

Efforts to improve public coverage programs have long been stymied by the prevalence of antiquated IT systems that are the source of numerous consumer issues such as confusing and conflicting notices, lost eligibility records, or insufficient data to measure program performance. Meanwhile the state of technology and web-based services has advanced significantly, leaving many Medicaid systems in the dark ages. Technology is needed to not only support consumer self-service and program evaluation but also to make government work better—more efficiently and cost-effectively. Spurred by the need to implement new rules and procedures and motivated by extensive federal funding, states can no longer afford to be pound wise and penny foolish in developing or adopting state-of-the-art technology, at least for their Medicaid programs. Now is an opportune time for states and a critical juncture for consumer advocates to engage to ensure that the systems developed today not only resolve the problems we have worked to remedy for years, but also propel public coverage programs into the 21st century.

Resource List

State documents (such as RFPs or grant proposals) may be posted on state websites, particularly in states building a state-based exchange. Other useful sources of these documents include these websites:

- State Refor(u)m maintained by the National Academy of State Health Policy at http://www.statereforum.org/.
- Kidswell Campaign funded by Atlantic Philanthropies and maintained by Manatt Health Solutions at http://www.kidswellcampaign.org/.

Helpful federal documents related to eligibility and enrollment systems include:

- Federal Funding Opportunity Announcement for Exchange Establishment Grants at: http://www.grants.gov/search/basic.do and

searching for CFDA number 93.525.

- The final rule on Federal Funding for Medicaid Eligibility Determination and Enrollment Activities (otherwise known as the 90/10 funding rule) at http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf.
- Enhanced Funding Requirements: Seven Conditions and Standards, Version 1.0, April 2011 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf
- Enhanced Funding Requirements: Expedited Advance Planning Document Checklist at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Expedited-Advanced-Planning-Doc-Checklist.pdf
- Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0, May 2011 at http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf.
- Information regarding the Temporary Exception to Cost-Allocation Requirements at http://www.cms.gov/smdl/downloads/tri-agency.pdf.
- Related Answers to Frequently Asked Questions:
    - http://www.medicaid.gov/State-Resource-Center/Ask-Questions/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf
    - http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost-Allocation-QAs-10-05-12.pdf
    - http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf

Endnotes

1. As of July, 2012, 49 states had submitted applications requesting enhanced federal funding to upgrade or replace their Medicaid eligibility and enrollment systems. Source: http://www.statehealthfacts.org/comparemaptable.jsp?ind=1065&cat=17.
2. Roughly 33 million people are estimated to enroll in Medicaid or qualify for advanced premium tax credits to subsidize premiums and cost-sharing in Qualified Health Plans (QHPs) in the Exchange. M. Buettgens, J. Holahan, C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," Urban Institute (March 2011).
3. For more information on the welcome mat effect, see http://www.shadac.org/blog/medicaid-expansion-out-woodwork-or-welcome-mat.
4. Federal regulations establish new standards for determining eligibility when electronic data sources and information provided by the applicant or enrollee are reasonably compatible. The exchange (at 45 CFR 155.300(d)) must consider information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. In Medicaid (at 42 CFR 435.952(c)), an individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual. (1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.
5. As of January 2012, only 34 states offered online applications for Medicaid for children. Source: M. Heberlein, T. Brooks, J. Guyer, S. Artiga, J. Stephens, "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012," Kaiser Commission on Medicaid and the Uninsured (January 2012).
6. For more information on 90/10 funding for Medicaid eligibility systems, see http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-

9340.pdf

7. For more information on the cost-allocation exception, see http://www.cms.gov/smdl/downloads/tri-agency.pdf.
8. States seeking to operate a state-based exchange or electing to participate in a state partnership exchange must submit a complete exchange blueprint no later than 30 business days prior to the required approval date of January 1 (November 16, 2012 for plan year 2014). Source: cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.
9. For a map of state exchange activities, see the Kaiser State Health Facts website at: http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17.
10. M. Tutty & J. Himmelstein, "Establishing the Technology Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the Early Innovator and Advanced Implement States," National Academy of Social Insurance (September 2012).
11. For more information on shared eligibility services, see http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf.
12. As of January 2012, 44 states operated Medicaid IT systems that also determine eligibility for other public benefits such as the Supplemental Nutrition Assistance Program (SNAP). Ibid (4).
13. For more information on IT Gap Analyses, see Appendix C of the Exchange Establishment Grant Funding Opportunity Announcement at http://cciio.cms.gov/resources/fundingopportunities/foa_exchange_establishment.pdf.

Authors: Tricia Brooks and Julie Silas

Julie Silas, Senior Health Policy Analyst, at Consumers Union served as a consultant on this project. Consumers Union (CU), the policy and advocacy division of Consumer Reports, is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #1

Will the online application and consumer web-based services be easy-to-use?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #1— ensuring that online applications and web-based services are easy for consumers to use and help consumers make informed plan choices.

Today, technology is easier to use than ever before. Many, if not most, consumers are accustomed to using web-based services for banking, making purchases, and booking travel. Yet, currently only about two-thirds of states have online applications.[1] Going forward, all of the insurance affordability programs (Medicaid, CHIP, and coverage through an exchange) must provide consumers with the ability to apply online, as well as over the phone, via the mail, or in person.

The IT system design for health care coverage under the ACA should make web-based access to coverage easy-to-use and accessible for consumers.[2] Factors such as what the web-based services will look like to consumers (also called the customer portal or consumer/user interface), whether a person can browse anonymously on the site, and what languages the web applications will be translated into are critical. Consumer testing with different types of people expected to access the system will be paramount to assuring ease-of-use.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Will the* **website** *that provides access to the online application be* **welcoming** *and* **easy to maneuver***?* The appeal of the website will be important to encourage consumers to explore their options and take action to secure health coverage.

- *Does the system allow consumers to* **anonymously search** *the website to learn more about the health coverage programs and plans available to them?* Individuals should be able to browse the website without being required to share any personal information. Allowing for anonymous shopping will provide a sense of privacy, especially to those who may wish to explore their options online but apply through a different mechanism, such as over the phone or in person. The system should not capture information (including the user's internet protocol (IP) address) "behind-the-scenes" without giving consumers an opportunity to affirmatively consent for personal data to be collected and saved (or "cached"). The technical design of the site should support this policy.

- *What will the* **user interface** *and* **online application** *look like?* The user interface should be designed to help guide consumers through the process. How well it is constructed will impact the number of consumers who are successful in navigating the system, rather than abandoning it in frustration.
  - Is the state planning to incorporate the "user interface" model created through the Enroll UX 2014 project? Enroll UX 2014 establishes a model for public and private health coverage enrollment and provides a design reference for state and federal health insurance affordability programs, developed collaboratively in a public-private partnership between eight national and state foundations, the federal government, and 11 participating states. It is available for every health insurance exchange, including the FFE, and Medicaid agency to use in its operations.[3] Will your state adopt the Enroll UX 2014 template wholesale, draw on its ideas and design features, or design its own user interface? Each state will have to weigh the value of using or adopting a pre-designed template, adapting an online application developed by another state, or creating a new interface that is tailored to the needs of the state.

- *Will all user interface components use* **plain language** *at an* **appropriate literacy level** *and be* **accessible to persons with disabilities***?* Federal regulations require that websites meet certain accessibility standards,[4] and additional federal guidance is expected on this topic.[5] In the meantime, several questions can draw attention to these issues as the IT systems are being designed and built.
  - Are the IT developers required to ensure that the reading level of the website content is appropriate for individuals with **limited English proficiency** (LEP)?
  - What **languages**, other than English, will the website be translated into? Will the online application be available in additional languages?
  - How will consumers who speak other languages be informed of access to **interpretation/translation** services?
  - What considerations are included in the process to ensure the website is **accessible to individuals with disabilities**?

- *Will the system have a* ***screening tool*** *for consumers to test their potential eligibility for financial assistance for coverage before starting the application process?* One of the most prevalent barriers to Medicaid and CHIP today is that consumers believe they earn too much money to qualify for coverage. An easy-to-use screening tool will help overcome this barrier and give consumers the confidence that completing the application process for financial assistance will be worth the effort. Ideally, the screening tool will include an **online calculator** that provides an estimation of the cost of premiums and limits on out-of-pocket cost-sharing for consumers who qualify for subsidized coverage in the exchange.

- *Does the online application provide* ***clear, basic instructions*** *on how it should be completed?* Does the website and application offer **consumer tools** such as an e-chat function, FAQs, audio visual application assistance (AVAA), links to more in-depth information, and other features? These tools will help support consumer self-service and decrease the need for facilitated assistance as consumers move through the system.

- *Will the online application suggest that prospective applicants* ***gather helpful information before starting the application*** *(e.g., social security numbers (SSN) of family members applying for coverage, last year's tax return, recent pay stubs, etc.)?* The application process will go more smoothly if consumers have needed information at their fingertips.

- *Will the online application flag sensitive or critical topics through* ***pop-up boxes*** *or "****alerts****?"* It is important to provide consumers with key information such as how an SSN will be used or the importance of reporting accurate income given repayment obligations for advanced premium tax credits.

- *Will the online application use* ***dynamic questioning*** *– that is skipping questions that are not relevant to the user based on information previously entered?* This approach will reduce the amount of information asked of consumers and make the process more straightforward and streamlined. When dynamic questioning is used, the order or **sequencing of requested information** matters and should be given careful consideration in the design phase.

- *Does the system enable a consumer to* ***start, stop, and return to the application*** *without having to resubmit information*? Is this functionality part of setting up an **online account** that provides additional features after the application is submitted, such as reporting changes in circumstances, paying premiums, tracking cost sharing, or initiating appeals? Online accounts are critical to maximizing the ability of consumers to manage their data while increasing state administrative efficiency.
    - Will the system limit the amount of time the online application remains "open" if the applicant has stopped entering data? Will it give a warning before "closing" the application? Will it **automatically save the application** before logging the consumer out? To protect personal information, open web pages should be closed after a period of inactivity, ideally without losing data entered by the consumer or someone providing assistance.

    - Does the website design offer the capability for a consumer to stop and save a partially finished application and complete it through a follow-up telephone call or in person? Consumers who are having difficulty using the website may want help to finish the process. Having the ability for consumer assistance staff to pick up where the consumer left off will be more efficient for everyone.

- *Will the online application provide navigation aids, such as a* **progress bar,** *that shows a consumer how far s/he has moved through the application and/or how much more information is needed before the process is completed?* It is helpful for consumers to be able to gauge their progress and estimate how much more time is needed to complete the process. If needed, they can be prepared to stop, save and return to the application at a later time.

- *How does the system* **improve communications** *with consumers?* Confusing and often conflicting notices have been an ongoing source of frustration for consumers and eligibility offices alike. New systems offer the opportunity to dramatically enhance the understandability of program information shared with consumers. Allowing consumers to go paperless and opt for electronic notices will increase the timeliness of communication while decreasing state administrative costs.

    - Does the system provide consumers the ability to choose a **preferred method of delivery** for future contact (email, text or mail)? Ideally, consumers should be asked to identify a preferred method for different types of communication (e.g., premium reminders, benefit information, renewal notices, etc.) and be able to easily change their preference at any time.

    - Are consumers able to **access and print their notices**? The system should **save all communications** in the online account so that the consumer can access and print notices, decision letters, and other pertinent eligibility and enrollment information for all family members.

    - **How long will communications be accessible** by the consumer? Consumers may need access to older notices for an extended period of time, particularly given that the income serving as the basis of an eligibility decision during open enrollment in any given year may be needed as consumers reconcile their premium tax credits more than a year and a half later.

- *Will the system* **track cost-sharing** *(i.e., deductibles, co-payments, and co-insurance costs) for all members of a family during the year to determine when they have met their annual cap?* Generally, health plans monitor out-of-pocket caps, but families could purchase different plans for different members. Will the exchange handle this function or at minimum provide an easy way for consumers to track their cost-sharing, such as providing for an interface to health plan IT systems that can supply the information? Given that the cost-sharing limits apply to the aggregate household out-of-pocket spending, consumers need an easy way to track combined costs for the entire family.

- *Is there a solid plan for thorough* **consumer-testing** *by a range of people who are expected to use the system?* Consumer testing is the most important way for states to

gauge the system's ease-of-use and identify areas where consumers may get hung up. Testing should occur at several different time periods in the IT development process, including early enough in the system's development to allow for feedback to be incorporated into the design and later to ensure that the final product adequately serves the consumers that will use the system.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

Other top consumer "Issue Areas" addressed in this series include:

- How will the system help consumers with special circumstances, such as immigrant families and children with divorced or absent parents? (#2)
- How will the website facilitate access to personalized help from the call center, navigators, or other assisters? (#3)
- How will the IT system use electronic data sources to verify eligibility in real-time? (#4)
- How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid, and CHIP? (#5)
- Will the web-based services help consumers compare, make an informed selection and enroll in a health plan of their choice? (#6)
- How will the system help people maintain and renew coverage? (#7)
- How will the system protect the privacy and confidentiality of personal information? (#8)
- Does the system provide clear information about grievance and appeal procedures and incorporate due process protections? (#9)
- What data will the system generate to evaluate program performance and consumer satisfaction? (#10)

Authors: Tricia Brooks, Georgetown Center for Children and Families, and Julie Silas, Consumers Union

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Endnotes

[1] For helpful information on state experience and best practices in the use of online applications, see: S. Gonzales, "Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement," Kaiser Commission on Medicaid and the Uninsured (June 2011).

[2] Specific requirements for exchange websites, can be found at 45 CFR 155.205(b).

[3] For more information on Enroll UX 2014, see www.**ux2014**.org.

[4] 45 CFR 155.205 (c) Accessibility. Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. (2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including (i) Oral interpretation; (ii) Written translations; and (iii) Taglines in non-English languages indicating the availability of language services.

[5] Federal Register/Volume 77, No. 59/Friday, March 27, 2012/Rules and Regulations/Page 18328.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #2

How will the system help people with special circumstances, such as immigrant families and children with divorced or absent parents?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #2— ensuring that web-based services are prepared to accommodate consumers with complicated or special circumstances.

The IT system should ensure that people with special circumstances understand how personal information will be used and how the programs work for their situations. For example, the manner in which the system asks questions about non-applicants, especially with regard to citizenship and numbers (SSNs) matters. Additionally, helping families determine which people should apply for a child's coverage when divorced parents have joint custody or parents live in different states? These and other circumstances present special situations that systems must take into consideration if they are to be fully streamlined and simplified.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *How will the system handle* **families with members eligible for different sources of coverage***?* Three quarters of parents qualifying for subsidized coverage in the exchange will have children eligible for Medicaid or CHIP.[1] In a number of states, lawfully residing children and pregnant women may be eligible for Medicaid or CHIP without having lived in the country for more than five years, while other adults in the family will qualify for

Box 57144 3300 Whitehaven Street, N.W. Suite 5000 Washington, DC 20057
T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

subsidized coverage in the exchange. States that elect for a state or federal exchange to make Medicaid and CHIP eligibility determinations will provide for more efficient and timely processing of enrollment for all members of the family. In bifurcated systems, where eligibility is merely assessed and applications or renewals are passed off for a full determination, there is greater potential for individuals to slip through the cracks unless care is taken to ensure a successful handoff between agencies.

- *How will the system deal with situations when a* ***child does not live with the parent who claims the child as a tax dependent****?* Children may qualify for Medicaid based on the financial circumstances of the parent who has primary custody. In other circumstances, a child will need to be enrolled in a QHP, possibly in a different state or coverage area than the parent who claims the child as a tax dependent. The exchange IT system must recognize and handle these circumstances so that the child can be enrolled appropriately.

- *How does the system provide coverage without delay for children who may have an* ***absent parent responsible for medical support****?* A number of states do not delay Medicaid coverage for eligible children if the custodial parent agrees to cooperate with efforts to enforce medical support. It is important that both state processes and systems be designed to support this approach.

- *How will the system deal with special issues and concerns impacting* ***immigrant families****?* Families with mixed immigration status may have concerns about the privacy and security of their personal information. Providing assurances that application information is used solely for determining eligibility for health coverage and making it clear that non-applicants are not required to provide an SSN will be important to these families.

- *How will the system support* ***people with limited English proficiency (LEP)****? Will the system be designed to record and track both spoken and written language preferences?* Will these data be transmitted to QHP and Medicaid managed care plans so they can also provide appropriate information and interpretation services? Consumers should be able to designate a preferred language that will then be used for all future communications. In turn, notices should be translated into the preferred written language. The system should also provide clear information on how to access interpretation services.

- *Does the system provide* ***assistive technologies,*** *including access to appropriate interpreters****, for persons with disabilities*** *who need special accommodation for communications?* The system must comply with all federal and state disability laws, including the ADA and Section 504 of the Rehab Act as required by law.

- *Is the system set up to assure that* ***pregnant women*** *get the most comprehensive coverage available?* Some pregnant women may be eligible for more than one category of Medicaid coverage, while other pregnant women may be eligible for both Medicaid and subsidized coverage under the exchange.[2] When individuals are eligible for more than one category of Medicaid coverage, they may select the coverage of their choice.[3] Does the system default to enrollment in the most robust and lowest cost option or allow the recipient to make a choice without a default? Depending on the coverage available, a

consumer's concern about cost may possibly be outweighed by the scope of benefits or being able to remain with the same provider. The system should provide clear information, so women can make an informed choice among options.

- *How will the system screen for non-MAGI categories of Medicaid for **individuals with disabilities or in need of long term care supports and services**?* By asking a few key questions, the system should be able to initiate further evaluation of eligibility for more appropriate coverage options for these groups. Meanwhile, the system should allow the applicant to complete the MAGI-based application process and be enrolled in coverage while awaiting a decision on eligibility for other categories of care.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

Other top consumer "Issue Areas" addressed in this series include:

- Will the online application and consumer web-based services be easy to use? (#1)
- How will the website facilitate access to personalized help from the call center, navigators, or other assisters? (#3)
- How will the IT system use electronic data sources to verify eligibility in real-time? (#4)
- How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid, and CHIP? (#5)
- Will the web-based services help consumers compare, make an informed selection and enroll in a health plan of their choice? (#6)
- How will the system help people maintain and renew coverage? (#7)
- How will the system protect the privacy and confidentiality of personal information? (#8)
- Does the system provide clear information about grievance and appeal procedures and incorporate due process protections? (#9)
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Endnotes

[1] L. Dubay and G. Kenney. Memorandum to Interested Parties re: The Need for a Seamless Enrollment System Under the Affordable Care Act, Urban Institute (2011).

[2] Medicaid and CHIP count the number of babies expected in a pregnant woman's household in eligibility determinations and states have the option to do this when determining eligibility for other family members. Unborn children are not counted in the household in determining subsidized coverage in the exchange.

[3] 42 CFR 435.404 The agency must allow an individual who would be eligible under more than one category to have his eligibility determined for the category he selects.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #3

How will the website facilitate access to personalized help from the call center, navigators, or other assisters?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #3— ensuring that web-based services provide **access to personalized help**.

Even when using the most well designed website, people will have questions and some will need help maneuvering through the system to access coverage. Key factors in determining how well the IT design provides access to assistance include whether technology-enabled tools (such as e-chat) are built in to promote self-service;[1] whether call center staff are able to view an application in progress; and how prominently the website enables consumers to search for and connect with navigators and other assisters who can meet their needs (i.e., language spoken, evening or weekend availability).

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *How does the system connect consumers with* ***call center help****?* Will calls or chats be directed to specific consumer assistance staff by differentiating whether there is a systems issue (e.g., "I can't get to the next screen") or an eligibility or enrollment question (e.g., which family members do I include in my household?). Some states may use their IT vendors to provide **"help-desk" type** assistance regarding systems functionality, while staff with eligibility and enrollment knowledge would deal with programmatic questions. If so, how will the system triage and direct consumer issues to the right person?
  - Does the system include a link to **FAQs** (frequently asked questions)? Does it include a **chat function** to provide quick answers to consumer questions? Alternatively, the

Box 57144 3300 Whitehaven Street, N.W. Suite 5000 Washington, DC 20057
T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

system might include a “**click to call**” function that sends a request for a consumer assistance staff member to call the consumer immediately or at a designated time. Studies show that even consumers who are confident they can apply online appreciate knowing that help is easily accessible.[2]

- Does the system enable **co-browsing** so that call center staff can see the same screen as the consumer? Co-browsing helps staff discern if there is a technical problem with the system or if the consumer needs help in completing the application or using other functions or tools available on the website.
- How will **systemic issues or recurring trouble spots** be identified? By tracking questions asked and problems reported by consumers via chat or through the call center, the agency can identify and remedy issues that impede consumer self-service. Additionally, the system can track recurring patterns of where consumers abandon the application or time-out signifying trouble spots that need attention.

- *How will the system help consumers access personalized help from **navigators** and other **consumer assisters**?* Will the system provide a listing and contact information for “official” navigators and other authorized assisters? Ideally, the system will allow consumers to search for assistance on a variety of criteria, such as type of organization, location, hours of operation, and the availability of specific types of services (such as languages spoken, in-home visits, etc.).

- *Will the online system have a **separate portal or entry point with a password protected login** for the call center, navigators, and other assisters to use in completing applications and otherwise facilitating eligibility and enrollment?* A separate portal would not be a separate website, but a different entry point than the one consumers use in applying on their own. It authenticates that the assister is authorized to help consumers and may provide different tools and functionality for assisters to use in facilitating enrollment. Most importantly, it protects the consumer by identifying the source of data in the system’s audit trail, enabling the agency to know that the information was entered or changed by an assister and not by the consumer directly.
  - How will the system require consumers to confirm that the navigator or assister has **permission to facilitate** the application and enrollment process? Will it occur before beginning the process or when they attest to their rights and responsibilities and “sign” the application? How does this work for assistance provided over the telephone?
  - Is there a **specific login** for navigators and assisters so that the system can distinguish who is entering data, rather than have the assister impersonate a consumer? In turn, does the system capture the login information as the source for all data entry and changes in its **audit trail**? An audit trail is a historical record showing the person who accessed the system, what changes were made, and what operations were performed.
  - Does the system appropriately **limit navigator or assister access** to consumer accounts for which they are authorized? Navigators and assisters should not be able to randomly browse consumer accounts, but only those that they have secured permission from a consumer to facilitate.

- Will there be a set date when an assister's **access expires** without the consumer affirmatively extending authorization? While consumers may need application assistance, they do not necessarily want assisters to access their personal information indefinitely. However, there may be cases where it is desirable to maintain access for a limited time. For example, after an application has been submitted but before a determination is made, further assistance may be needed for resolving inconsistencies.
- Does the system allow different levels of help and "permission" to view or change information and see eligibility determinations? States may tier assistance, with not all assisters trained to provide a full range of services (e.g., some assisters might be trained to assist with eligibility but not QHP selection). Some assisters may be authorized to assist with renewal and others not. These differing levels of authority indicate that different **levels of permission** are needed to protect access to personal information.
- Will the portal enable navigators and assisters to expedite communication with the agency when there is a problem with the electronic account or other issue that requires the agency's attention? For example, the system could offer a chat function within the navigator portal that is staffed by the most experienced eligibility workers to help resolve more complicated problems that experienced navigators are unable to handle on their own.

- *Will the system enable policymakers to collect data to* ***monitor and evaluate navigator and assister performance****?* It will be important for states to track their activity to ensure that the needs of consumers are best served. For example, what percentage of applications initiated does the assister complete and how many are successfully enrolled in coverage? Is the assister reaching the target audience that is the focus of their grant or contract? These and other data can be "mined" from the system to ensure that assistance programs are meeting their goals while protecting access to consumer information.
  - Will the IT system generate reports so that the exchange or other agencies will be able to identify patterns of behavior that suggest assisters are not providing impartial information on the full range of QHPs?
  - Will the system easily be able to shut down an assister account if the monitoring entity determines that the assister has violated state policies or procedures?
  - Will the system provide the functionality for consumers to report problems with an assister?

- *Does the website provide information to connect consumers to insurance* ***brokers and agents*** *if they are authorized to sell QHPs in the exchange?*[3] Consumers should be able to easily confirm that a broker or agent is registered and has permission to facilitate the enrollment process. Many of the IT-related issues regarding navigators and other assisters apply equally to brokers. Others should be tailored to the different role that agents and brokers may play.
  - Will the broker-related section of the website alert consumers if brokers and agents are not required to provide consumers with information about the full range of QHPs? Federal regulations do not require brokers and agents to provide impartial information

about all available QHPs, although a state may chose to do so. Consumers should be alerted if brokers are not required by the state to inform consumers about the full range of QHPs.

  - Will the website display or make available information about how much the broker or agent is being paid by issuers/health plans? Consumers should know if a broker or agent is commissioned for selling a policy to them.
  - Will the system provide a web portal or entry point for agents and brokers to use? Will it be the same portal as navigators, or one that provides different functionality to reflect the different role that brokers play? If brokers are paid commissions by the exchange or QHP, the system could track information to expedite the reporting and payment of commissions.
  - Will the exchange collect and report the same data for monitoring and evaluating agents and brokers as for navigators? As noted above, federal regulations do not require agents and brokers (unlike navigators) to provide information to consumers on the full range of QHPs or to offer impartial guidance. If a state opts to require brokers to do so, the system needs to track and analyze data in its audit trails in order to ensure that brokers are meeting this state requirement.

- *How will the IT system receive electronic information from* ***web-based broker/agents*** *for enrollment?* Web-based brokers are required to follow specific rules for displaying all QHP information[4] and their role raises a host of policy questions and a need for oversight by the exchange that are beyond the scope of this brief.[5] However, the most important question is whether the IT system will be constructed to accept enrollment from web-based brokers only if they meet federal and state requirements. Both eligibility for financial assistance and enrollment only can be handled directly through the exchange website.[6] If and how the system receives enrollment data through web-based brokers and transmits those data as "official enrollment" to QHPs will be important in assuring critical consumer protections.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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- How will the system help consumers with special circumstances, such as immigrant families and children with divorced or absent parents? (#2)
- How will the IT system use electronic data sources to verify eligibility in real-time? (#4)
- How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid, and CHIP? (#5)
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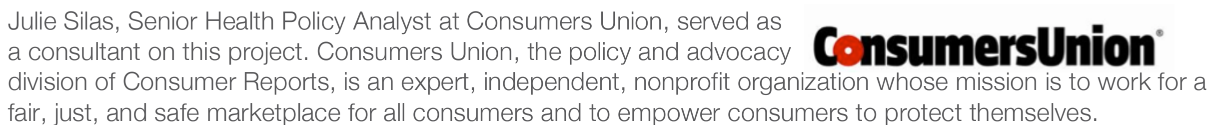

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Endnotes

[1] For more information on technology-enabled consumer assistance, see "T. Brooks, J. Kendall, "Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and Exchanges," Robert Wood Johnson Foundation (July 2012).

[2] Washington State Health Benefit Exchange: "Potential Role and Responsibilities of Navigators" (July 2012). http://www.hca.wa.gov/hbe/documents/HBE_Policy_Navigator_Paper_Draft.pdf

[3] States have the flexibility, but are not required, to allow insurance brokers and agents to sell QHPs. For more information on the role of agents and brokers, see 45 CFR 155.220.

[4] 45 CFR 155.220(c)(3) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must: (i) Meet all standards for disclosure and display of QHP information contained in § 155.205(b)(1) and (c); (ii) Provide consumers the ability to view all QHPs offered through the Exchange; (iii) Not provide financial incentives, such as rebates or giveaways; (iv) Display all QHP data provided by the Exchange; (v) Maintain audit trails and records in an electronic format for a minimum of ten years; and (vi) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in § 155.205(b) instead at any time.

[5] For more information about important consumer protections when allowing web-based brokers, see "Recommended Consumer Protections for Web-based Agents and Brokers offering Exchange Coverage" from Consumers Union at http://www.consumersunion.org/pub/pdf/web-based-brokers-recommendations-9-5-12.pdf.

[6] 45 CFR 155.220 (c) Enrollment through the Exchange. A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if— (1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Web site as described in § 155.405; (2) The Exchange transmits enrollment information to the QHP issuer as provided in § 155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #4

How will the IT system use electronic data sources to verify eligibility in real-time?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #4— ensuring that consumers are able to sign up for coverage through online processes that includes electronic verification of eligibility in real-time.

Tapping electronic sources of data will provide states with more efficient, cost-effective, and accurate ways to verify eligibility. The goal is to be able to make an immediate – or real-time – eligibility decision as soon as the consumer has completed the application process. To achieve real-time eligibility and enrollment, the IT system will need to maximize the potential for electronic verification of eligibility factors, rather than through unnecessary paperwork, by interfacing with the federal data services hub and state sources of data. The system should also include back-up options to electronic verification, such as allowing applicants to upload a scanned image or picture of a paper document, if documentation is needed or if it provides more accurate information than electronic sources. While real-time eligibility may not be possible if a review of documentation is required, enabling electronic submission can lead to a faster eligibility decision.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Do IT-related documents confirm that the state is developing the capacity to connect to the **federal data services hub**, as required by federal law?* To increase efficiency, timeliness, and accuracy by reducing the paperwork burden on states and applicants, the ACA accelerates the use of electronic data sources to verify eligibility. The federal

Box 57144 3300 Whitehaven Street, N.W. Suite 5000 Washington, DC 20057
T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

government is building a data services hub that will consolidate access to relevant tax data, as well as citizenship, incarceration, and immigration status from federal sources including the Internal Revenue Service, the Social Security Administration, and the Department of Homeland Security.[1]

- *How does the system propose to* **link to other relevant and required state agency databases** *to verify eligibility, such as the unemployment agency, the state wage information collection agency, or other public programs?* Federally-funded programs, including Medicaid, are required to have an income and eligibility verification system in place to secure data from specific state sources.[2] The expectation is that states will tap these sources electronically but, as noted below, there are a variety of ways to do so. How the state plans to access state sources of data will impact the extent to which the system can make a "real-time" (immediate) or "near real-time" (within 24 hours) eligibility determination.
    - Does the state propose to establish **a state data services hub** to streamline access to these critical data sources on a real-time basis? Creation of such a data hub can expedite access to and organize data from multiple sources.[3] It can be particularly efficient in eliminating the need for eligibility workers to learn and maneuver multiple, different databases individually.
    - If a state-level data services hub isn't created, does the new IT infrastructure propose to automatically send **individual data requests** to each database to accommodate an immediate look-up on a case-by-case basis?
    - Alternatively, will there be a behind-the-scenes **batch process** that incorporates multiple individual requests for data? While batch processes can be conducted multiple times during a day, they are often done only periodically (i.e., daily or weekly), thus batch processing can impede real-time determination of eligibility.
    - Or, will the state accept the individual's **self-attestation** and conduct **post-eligibility verification** through electronic batch processes with relevant sources of data? This process could result in discrepancies if information obtained from other sources (i.e., quarterly wage reports) at a future date differs from those used for the initial eligibility determination.[4] As such, states must seek to resolve these with the consumer.
    - Does the IT system provide the functionality to support **policy decisions** on self-attestation, reasonable compatibility (when data reported by the consumer are not an exact match to data obtained electronically, but do not impact eligibility), and how to resolve conflicts in data received from multiple electronic sources? Each of these represents a critical policy decision with implications beyond the scope of this toolkit; however, they will need to be made in conjunction with the system development to ensure that the IT infrastructure accounts for them.
- *How will the IT system* **store information** *received from other data sources?* The more often that data is exchanged between systems and the more places it is stored, the greater the risk that privacy and security could be compromised.

- Will the system simply view and confirm eligibility or will relevant data be exported to populate specific fields and stored in the eligibility system?
- Or, will data records secured through matches be archived and accessible through a separate secure data warehouse (and perhaps linked to a state data services hub)?
- Regardless of how the data is stored, will consumers have access to the data that was used to determine their eligibility? It is important for consumers to be able to see what data was used to determine their eligibility, especially if discrepancies arise that need to be explained.

- *For FFE or state/federal partnership states, is the IT system designed to allow the* ***federal exchange access to a state-level data service hub or individual state sources of data*** *to verify information that may be more current than what is federally available?* Access to current income data sources is critical for the FFE to accurately determine or assess Medicaid eligibility.[5]

- *Is the system designed to accommodate other* ***backup options to electronic verification****?* Federal regulations allow states to request additional information from individuals only if the required data cannot be obtained electronically or if the data obtained electronically is not reasonably compatible with the information provided by the individual.[6] However, there will be situations when electronic data do not reflect current circumstances and individuals must be provided an opportunity to provide documentation if a state does not accept self-attestation. In such cases:
  - Does the system provide the ability for a consumer to **upload a scanned document or electronic image**? Alternatively, can consumers print a fax cover sheet with a barcode associated with their account so documents can be submitted via fax but automatically linked to the proper account? Submitting documents electronically in a way that is automatically connected to the consumer's account will not only avoid lost paperwork, but also expedite receipt and review of verifications, leading to faster enrollment.
  - Does the system provide for **electronic document storage** and management of these documents? Can consumers access them through their online account?
  - How does the system **trigger action needed** when a document has been received? Designing an alert that would notify an eligibility worker to take action on verification documents would help ensure consumers are enrolled as quickly as possible.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of

IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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Endnotes

[1] 42 CFR §435.959 requires that states use the federal data services hub in determining eligibility for all insurance affordability programs. For additional information about the federal hub, see http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf.

[2] Social Security Act §1137.

[3] For an example a state data services hub, see E. Rodman, "Using Electronic Data to Make Enrollment Easier: A Closer Look at Utah's eFind System," Enroll America (August 2011).

[4] For an example of a post-eligibility verification process employed in Oklahoma, see http://www.statereforum.org/blog/oklahoma-online-enrollment

[5] Regardless of whether a state operates a state-based exchange, uses the FFE or participates in an FFE partnership, the exchange must either determine or assess Medicaid eligibility. For further information, see http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf

[6] 42 CFR §435.952(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #5

How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid and CHIP?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

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To achieve the promise of health reform in the most streamlined and efficient manner, the relationship between public coverage programs and the exchange needs to be well coordinated. This is true whether the state is establishing its own exchange or relying on the federally-facilitated exchange (FFE) or partnership model. Vital to establishing seamless access to all of the insurance affordability programs are linkages between programs that are timely and invisible to consumers and successful screening for (non-MAGI) Medicaid for people with disabilities or in need of long-term care services.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *For states building a state-based exchange, is the state planning to use a* ***single, integrated eligibility system for all public health coverage programs****, including the eligibility for advanced premium tax credits (APTCs) and cost-sharing reductions in an exchange?* If so, which agency is responsible for operating and maintaining the system? A single, integrated eligibility system for all the insurance affordability programs will be the most cost-effective to build and maintain. However, it requires close coordination and collaboration between agencies and, ultimately, one agency must take primary responsibility for managing vendor relationships and ongoing maintenance of the system.

Box 57144 3300 Whitehaven Street, N.W. Suite 5000 Washington, DC 20057
T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

- *If states are operating separate systems for Medicaid and the exchange, is there one* ***shared eligibility service or rules engine***[1] *for just the modified adjusted gross income* ***(MAGI)-based coverage options****, including Medicaid, CHIP and subsidized coverage in the exchange?* The rules engine is the "brains" of the MAGI eligibility system. It includes all the rules or business requirements for counting income and household size (including exceptions for Medicaid as appropriate) needed to determine the correct eligibility pathway for each applicant. In order to avoid duplication of systems, even states that are bifurcating the eligibility and enrollment process between Medicaid and the exchange can use the same rules engine to ensure consistency in the eligibility determination process. Additionally, federal funding is predicated on states using a shared eligibility service. In states with a shared rules engine, the following questions will be important:
    - Will each of the different agencies have access to the rules engine at all times? All agencies should have equal access to the shared eligibility service.
    - If the exchange only assesses (rather than determines) eligibility for Medicaid/CHIP, how will the system **electronically transfer all data collected from the application and verification process,**[2] as required by federal regulations? It is important that both the exchange and Medicaid systems be able to transfer client "electronic accounts" back and forth. An electronic account contains all of the information provided in the application, as well as any verifications and notices. This will ensure that consumers are not asked to provide information already captured by the system.
    - How will the separate IT systems account for **"handoffs" or transfers between agencies**? Each system should acknowledge receipt of a transfer and report final disposition of the eligibility record (i.e., did the consumer get enrolled?) in order to make sure that handoffs are successful and result in a final eligibility determination and enrollment.

- *For states not* ***integrating non-MAGI Medicaid eligibility*** *into the single system or shared eligibility service, how will the online application screen and transfer data for people who might be eligible for Medicaid under a disability or senior/long-term care category?* Implementation of expanded health coverage options should not impede the ability of consumers with more intensive health care needs to access more robust coverage options. Additionally, the system should be set up to enroll applicants who are income-eligible under MAGI, while their eligibility for disability or long-term care services is being evaluated.

- *Is the system built to incorporate eligibility determinations for* ***other human services programs*** *such as subsidized childcare, Temporary Assistance for Needy Families (TANF), and the supplemental Nutrition Assistance Program (SNAP)?* Some states will opt to build the capacity for integrating human services eligibility determinations into the IT system now. Other states, due to time constraints, may choose a phased-in approach. If integration at the outset is not possible, will the system screen for and refer applications to other social service programs? Transferring data to other programs for consumers who give consent will ensure that they do not miss out on vital benefits that improve the financial security and health of their families.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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Endnotes

[1] For more information on shared eligibility services, see http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf.

[2] 45 CFR 155.302(a) (3) Applicants found potentially eligible for Medicaid or CHIP. When the Exchange assesses an applicant as potentially eligible for Medicaid or CHIP consistent with the standards in subparagraph (b)(1) of this section, the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface, promptly and without undue delay.

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #6

How will the web-based services help consumers compare, select and enroll in the health plan of their choice?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help prepare for this task, we have created "Eligibility and Enrollment Systems: Advocate's IT Toolkit," which provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #6 – ensuring that web-based services allow people to compare, make an informed decision, and enroll in the health plan of their choice.

A key goal of the ACA is to provide consumers with comparative data to make an informed plan selection in the exchange. The ACA requires that IT systems enable consumers to compare, select, and enroll in a specific health plan as soon as eligibility is determined. This same functionality could provide a more streamlined way for eligible families to select Medicaid managed care plans. Key questions about whether the system makes it easy to enroll in a plan include: What kind of information will be available to consumers to help them compare and choose a plan that meets their needs in either the exchange or Medicaid? How will that information be presented? Will the system allow consumers to enroll and then pay premiums online so that the effective date of coverage is not delayed?

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Does the website design include* all of the necessary information *to help consumers make an informed choice of plans?* Federal regulations require exchange websites to provide comparative QHP information, including premiums and cost-sharing details, summaries of benefits and coverage, plan level (i.e., bronze, silver, gold, platinum), quality ratings, consumer satisfaction surveys, medical loss ratios, and more.[1]

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- *Does the website* **help consumers understand how to use the information** *to evaluate a plan?* For example, does it describe what's in a "summary of benefits and coverage?" Does it explain what "medical loss ratio" is? Providing links to documents and charts of numbers may not be sufficient to help consumers make use of the information to select a plan that meets their needs.

- *Can consumers easily* **view and compare plan information***?* Does the system merely provide information about each plan or does it have the enhanced ability to compare plans side-by-side? Systems that provide different ways to search, sort, or filter QHP options based on an applicant's personal criteria, will make the shopping experience more consumer-friendly. Key elements that would be helpful to filter include: plan type (e.g., silver or bronze), participating providers, total estimated costs, benefits package, premium costs, deductible, maximum out-of-pocket costs, service area, and quality ratings.

- *Does the system* **initially display all plans** *before offering consumers an opportunity to select, view and compare specific plans?* Just as it is important that navigators and other assisters provide consumers with information about the full range of QHPs, the website should do the same.

- *As consumers view and compare options after the initial display showing all plans, are there a reasonable or* **"manageable" number of QHPs displayed** *at any given time?* Comparing too many plans at once can be difficult to comprehend, however, consumers (not the system) should be in charge of selecting any criteria used to filter out plans. Additionally, providing too much detail about a specific plan or plan feature can make it difficult to digest the information. Rather than displaying lots of dense text, it will be helpful to allow consumers to click through for more detailed information. When less than the full range of plans is displayed, there should always be a clear indicator that not all choices are currently displayed.

- *Is there a planned* **default sort order for QHP display***?* The order in which plans are displayed could influence a consumer's choice. It is important that this be taken into consideration in providing plan information. For example, the system might display plans sorted by total estimated out-of-pocket costs or plan level.[2]

- *Does the system design include the functionality for* **Medicaid managed care plan comparison and selection***?* Today, many states use expensive enrollment broker services for Medicaid managed care enrollment with mixed results.[3] Often there are delays in enrollment and many individuals ultimately are automatically assigned to plans. Allowing consumers eligible for Medicaid to compare and select plans in the same way as choosing a QHP in an exchange will be advantageous to both the consumer and the state.

- *Does the system design anticipate offering* **advertising or sponsored links on the exchange website***?* For many years, consumers have been protected from marketing by Medicaid managed care plans and it is equally important to protect consumers from

marketing in an exchange, as advertising could unduly influence a consumer's plan selection. If an exchange does allow marketing, the website should be designed to ensure that advertisements or links do not appear in areas where consumers will be comparing and selecting plans.

- *Will the* **premium and cost-sharing calculator***, required by federal regulations, be readily accessible and easy-to-use?* Since tax subsidies are based on "silver" plans, selection of different plans could increase a consumer's premium and cost-sharing liability. It is important that consumers are informed when a specific plan would impact their financial share of the cost.

- *Once a consumer selects a plan, how will the system handle* **premium payment***, which is required before coverage becomes effective?* Does the system allow consumers to pay premiums to the exchange or only directly to issuers? In the latter case, does the exchange website facilitate payment by providing direct links to issuer websites? Having an exchange collect premiums can be advantageous. Given that families may choose different plans for different household members, the exchange can consolidate premiums into one payment (premium aggregation). Additionally, an exchange can uniformly deal with late, partial, or disputed payments. Many low-income families do not have bank accounts and struggle to make ends meet. This must be taken into consideration when providing payment options and collecting overdue premiums, whether handled by the exchange or the QHP issuer.

- *After the consumer selects a plan, will the system* **confirm enrollment** *and provide a link to the "summary of coverage and benefits"?* Acknowledging enrollment will keep consumers informed and likely reduce the volume of calls to the exchange from consumers checking on the status of their enrollment.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

Other top consumer "Issue Areas" addressed in this series include:

- Will the online application and consumer web-based services be easy to use? (#1)

- How will the system help consumers with special circumstances, such as immigrant families and children with divorced or absent parents? (#2)
- How will the website facilitate access to personalized help from the call center, navigators, or other assisters? (#3)
- How will the IT system use electronic data sources to verify eligibility in real-time? (#4)
- How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid, and CHIP? (#5)
- How will the system help people maintain and renew coverage? (#7)
- How will the system protect the privacy and confidentiality of personal information? (#8)
- Does the system provide clear information about grievance and appeal procedures and incorporate due process protections? (#9)
- What data will the system generate to evaluate program performance and consumer satisfaction? (#10)

Authors: Tricia Brooks, Georgetown Center for Children and Families, and Julie Silas, Consumers Union

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Endnotes

[1] (b) Internet Web site. The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and: (1) Provides standardized comparative information on each available QHP, including at a minimum: (i) Premium and cost-sharing information; (ii) The summary of benefits and coverage established under section 2715 of the PHS Act; (iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act; (iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act; (v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act; (vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158. (This section of the federal regulations establishes additional requirements on exchange websites not included in this excerpt.)

[2] For more information on QHP display issues, see "Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices," Consumers Union (July 2012).

[3] K. Gifford, V. Smith, D. Snipes, J. Paradise, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey" Kaiser Commission on Medicaid and the Uninsured (September 2011).

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #7

How well will the system help people maintain and renew coverage?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #7— ensuring that web-based services improve retention by making it **easy for consumers to maintain and renew coverage.**

Maintaining continuous coverage is critical to improving health outcomes and measuring the quality of care. The IT system should be designed to make it easy for eligible consumers to maintain and renew their health coverage. It is important to assess how the system proposes to handle reported changes in circumstances and how well the system is able to access and use data available electronically to renew coverage automatically with minimal intervention from the consumer.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Do the web-based services or online account allow **individuals to report changes in circumstances**?* Ideally, individuals should be able to login into their account and make changes to their personal information, including adding or removing a family member, changing an address, or updating employment or income information. Such changes, once "saved" by the consumer, should (when applicable) trigger a review of eligibility and new plan selection.

- *Does the system inform enrollees **how to get help** when reporting changes in circumstances?* The website should always prominently display information about how to get help, either through the call center or directly from navigators or other assisters. This is

particularly important if an update to a consumer's income results in a change in coverage or to premium and cost-sharing requirements.

- *Does the system notify enrollees of* **alternative methods to report changes** *in circumstances when electronic means are not preferred or accessible?* Consumers should be able to report changes in multiple ways (online, in-person, mail, phone).

- *Does the system allow enrollees to* ***upload scanned documents or electronic photos of documents*** *if necessary to verify changes?* Given that recent changes may not be reflected in electronic data available to the agency, the ability to submit electronic documents will help ensure a smooth and timely process for verifying changes.

- *Is the system set up to do* **automatic reviews** *of ongoing eligibility before sending out annual renewal notices?* To improve retention, promote continuous coverage, and streamline renewals, states are required to review current electronic data to determine if individuals enrolled in Medicaid can be determined eligible for ongoing coverage.[1] Likewise, individuals enrolled in QHPs can authorize the exchange to look at their most current tax data (for up to 5 years[2]) to determine eligibility and the corresponding level of financial assistance for the upcoming year. In both cases consumers must be notified of the results and given an opportunity to report changes online, as well as through other means of submission (phone, mail, in-person). Any new information provided by enrollees must also be verified by relying on electronic data sources to the greatest extent possible.

- *How does the system handle Medicaid renewals when data is not available to automatically renew coverage?* States are required to use a **pre-populated renewal form** and provide consumers with multiple ways to respond (online, in-person, mail, phone). Ideally, consumers will be able to select their preferred method of receipt of the pre-populated renewal through their online account.[3] Multiple, friendly reminder notices, if action is required at renewal, will increase retention rates and avoid unnecessary churn.

- *Does the system design allow an enrollee to* ***review and affirm the pre-populated renewal form or provide updated information online****?* If all of the information on the form is accurate, consumers should not be required to provide additional information. At state option, a signature at renewal may be required,[4] although consumers must be given the option of signing electronically, over the phone, or through the mail. If new information is required, does the system allow consumers to manage the process directly through their online account?

- *Are the same streamlined processes available at application also available at renewal?* Many of the system features used to ensure a smooth, streamlined process at application (see Issue Area #1) are applicable at renewal. Consumers should be encouraged to **gather helpful information** (i.e., specific documentation regarding current income or other changes in circumstances) before starting the renewal process. The system should facilitate the renewal process by providing clear information and instructions for responding to a renewal form online, including flagging key or sensitive information through **pop-up boxes** or "**alerts**," such as the importance of accurate income reporting to avoid repayment obligations for advanced premium tax credits. And as always, the system

should prominently display how enrollees can obtain **direct consumer assistance** during the renewal process.

- *How does the system inform and allow individuals enrolled in either Medicaid managed care plans or QHPs to select new plans during the annual open enrollment period that coincides with renewal?* Consumers should be reminded and given an **opportunity to change plans** at each annual renewal before they are automatically re-enrolled in the current plan. The online plan comparison and selection process should mirror that available at initial enrollment (detailed in Issue Area #5).

- *Does the system design assure* ***seamless transition*** *to a new health insurance option without any break in coverage following changes in program eligibility at renewal or mid-year?* Whether precipitated by a change in circumstances or the annual renewal, there should be automatic electronic transfers of the consumer's account between programs, which trigger any next steps required by the agency or consumer.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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- Will the web-based services help consumers compare, make an informed selection and enroll in a health plan of their choice? (#6)
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Endnotes

[1] 42 CFR 435.916(a)(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under § 435.948, § 435.949 and § 435.956 of this part. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this chapter, notify the individual— (i) Of the eligibility determination, and basis; and (ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a) of this subpart, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

[2] 45 CFR 155.335(k) Authorization of the release of tax data to support annual redetermination.(1) The Exchange must have authorization from an enrollee in order to obtain updated tax return information described in paragraph (b) of this section for purposes of conducting an annual redetermination. (2) The Exchange is authorized to obtain the updated tax return information described in paragraph (b) of this section for a period of no more than five years based on a single authorization, provided that— (i) An individual may decline to authorize the Exchange to obtain updated

tax return information; or (ii) An individual may authorize the Exchange to obtain updated tax return information for fewer than five years; and (iii) The Exchange must allow an individual to discontinue, change, or renew his or her authorization at any time.

[3] 42 CFR 435.916 (a) (3) Use of a pre-populated renewal form. If the agency cannot renew eligibility in accordance with paragraph (a)(2) of this section, the agency must— (i) Provide the individual with—(A) A renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility. (B) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a) of this part, and to sign the renewal form in a manner consistent with § 435.907(f) of the part;

[4] There is no federal requirement for signature at renewal. Source: Centers for Medicaid and Medicare Services (CMS), "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Coverage" (August 2001).

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #8

How well will the system protect the privacy and confidentiality of personal information?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help prepare for this task, we have created an "Eligibility and Enrollment Systems: An Advocate's IT Toolkit," which provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #8 – ensuring that web-based services build in **privacy and confidentiality protections**.

Assuring privacy and confidentiality of personal information is critically important to instill consumer confidence and trust in the system. Strong privacy and security protections need to be incorporated into the system on many levels. How will the system communicate its privacy protections to users? What steps can consumers take to correct or delete inaccurate information? What remedies are in place for breaches of security? These are key questions that states will need to address in deploying new systems.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Will the web-based application automatically inform individuals about* ***what individually identifiable information will be collected or accessed*** *by the system, how that information is used and disclosed to others, how long it is retained, and whether and how individuals can exercise choice over such collection, use, and disclosure?* The system should communicate privacy and security policies and procedures in a manner that is appropriate and understandable to all individuals who may interact with the system.[1]

- *Will the system request that individuals* ***consent to data collection*** *before an actual application is initiated?* After communicating the types of data that will be collected and accessed, the system should confirm that the individual consents to use of their personally-identifiable data. Consent language should be conveyed in a manner that is easily understood

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T 202.687.0880 F 202.687.3110 E Childhealth@georgetown.edu

by consumers from all cultural, language, economic, educational, and health status backgrounds.[2]

- *How does the system conduct* ***initial identity verification*** *and how does it* ***authenticate repeat users*** *to protect access to personally identifiable information?* The system needs a secure means to authenticate that individuals are who they say they are so that personal information is protected and secure.[3]

- *Will the system provide individuals with easy* ***access to their own personal and financial information*** *collected or used by the system?* Individuals should have the ability to review all data that has been viewed or stored and is the basis for determining eligibility. Such data should be promptly available and presented in a format that is easy to understand.[4]

- *Does the system allow consumers to* ***dispute the accuracy or validity of personal data****?* Individuals should be able to have erroneous information corrected on a timely basis or to have a dispute documented if their request for correction is denied.[5]

- *How will the system communicate that consumers may qualify for unsubsidized coverage in the exchange if they do not wish to* ***share personal financial information*** *without discouraging potentially eligible consumers from applying for financial assistance?* A common misperception about Medicaid and CHIP eligibility today is that families believe they earn too much or cannot qualify because they are working. While individuals who do not wish to share specific information should be given the opportunity to do so, they should also be alerted to the fact they may qualify for lower cost coverage. Consumer tools such as subsidy screeners or premium and cost-sharing calculators, as noted in issue area #6, can be helpful in this regard.

- *Do the system specifications clearly identify the need for* ***secure transfer of data*** *that meets federal requirements?* In addition to providing secure transfers, privacy and security protection agreements must be in place between state agencies to govern the sharing and use of data. A lack of agreement between agencies can be a roadblock to building an effective IT system that maximizes the use of electronic data to determine eligibility in real time.

- *What are the* ***retention policies*** *for data that is collected and retained in the system?* Retention policies should accommodate legitimate agency needs for the data, but should not be longer than is necessary. For example, the retention period for information collected from ineligible persons should be different from the period for successful applicants who may want to rely on previously gathered information to facilitate more rapid renewal.[6]

- *What is the system's security plan to* ***detect, prevent, and mitigate any unauthorized access****, changes, or deletions of individually identifiable information?* While systems should include multiple levels of security to protect personal information, it must also recognize when a data breach occurs in order to trigger appropriate action to further protect consumers, including providing notice to individuals and appropriate authorities of privacy violations or security breaches. The notice should be in plain language and include all of the following: the name and contact information of the agency; a list of the types of personal information that were or are reasonably believed to have been the subject of the breach; the date of the notice;

the date or estimated date of the breach, and toll-free telephone numbers and addresses of the major credit reporting agencies, as well as their right to a free copy of their credit report.

- *What capacity will the system have to detect **improper access** by individuals who are authorized to view consumer personal information?* An eligibility or call center worker should access data only if they are directly assisting a consumer or have an administrative responsibility for processing eligibility for a specific consumer. (For instance, a worker should not access data for a neighbor or ex-spouse.) The system should be able to track when individuals view or make changes to a person's personal information. By developing audit trails and monitoring such activity, the appropriate agencies can detect improper access.

Summary

By searching IT-related documents including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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[1] 42 C.F.R. §155.260(a)(3) requires exchanges to develop privacy and security policies and communicate them clearly to potential users. For more information on the types of privacy and security protections required under the ACA, see, "Preserving Integrity in California's Healthcare Eligibility, Enrollment and Retention System (CalHEERS): Policy Recommendations " at http://yourhealthsecurity.org/wordpress/wp-content/uploads/2012/10/CalHEERS-Privacy-FINAL-4-25-12.pdf and http://yourhealthsecurity.org/wordpress/wp-content/uploads/2012/08/2012_04_Privacy-Matrix-CalHEERS_JS.pdf

[2] For more detailed information on consent, see, Rethinking the Role of Consent in Protecting Health Information Privacy, The Center for Democracy and Technology *2009).

[3] For more information on authentication, see, Electronic Authentication Guidelines, National Institute of Standards and Technology, (2006).

[4] 42 C.F.R. §155.260(a)(3)(i) requires that exchanges provide individuals a " simple and timely means to access and obtain their personally identifiable health information in a readable form and format."

[5] 42 C.F.R. §155.260(a)(3)(ii) requires individuals be able to dispute and correct inaccurate information in a timely fashion.

[6] For more information on individual access and retention policies, see, Individual Access: Connecting Patients with their Health Information, The Markle Foundation, 2012. http://www.markle.org/health/markle-common-framework/connecting-professionals/individual-access#sectIII

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Eligibility & Enrollment Systems:
An Advocate's IT Toolkit
Issue Area #9

Does the system provide clear information about grievance and appeal procedures and incorporate due process protections?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #9— ensuring that web-based services implement consumer protections.

Even if the IT system works the way it was intended, consumers will be denied coverage and want to question why they are not eligible for a specific program. The IT systems should provide clear information on grievance and appeal rights for consumers, as well as access to notices and information used to make eligibility and enrollment decisions. The systems should include clear pathways for consumers to initiate the grievance or appeals process and tools to exercise their due process rights.

To dig deeper into this issue area, advocates should review documents or ask project staff to answer these questions:

- *Will the consumer web portal display easy-to-understand information about what to do if they have a complaint or would like to file an appeal or grievance?* The website also should be used to connect consumers with health ombudsman or consumer assistance programs.[1] The website should provide taglines for non-English speakers to determine where they can obtain oral interpretation or language translation services to assist with a complaint or in filing an appeal.

- *Will the systems have the functionality to issue notices for eligibility determinations that comply with due process requirements?*[2] Notices should be translated into alternate languages for persons of limited English proficiency (LEP), and are compliant with ADA

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requirements for persons with disabilities. Additional federal guidance, expected in the near future, will provide accessibility standards that agencies will need to incorporate in their system functionality.

- *Will the system provide straightforward online access to notices and to* ***information used to make eligibility determinations****?* Does the system link the eligibility and enrollment determination to the appeals process? In order for appropriate entities to review and evaluate appeals on a timely basis, access to eligibility and enrollment information is needed. The system should store all correspondence, notices, data points, and documentation used to determine eligibility. Consumers should be able to access any information used for an eligibility determination, including denials or limits to advanced premium tax credits (APTCs) or other cost-sharing assistance. Consumers should also be able to access all documents and data used to determine eligibility.

- *Will the systems provide* ***specific functionality for handling appeals****?* While Medicaid has a long-standing appeals process,[3] regulations detailing the appeals process for the exchange have yet to be released. Additional features could be built into the system that incorporate appeals and grievance protocols in order to generate notices, track timelines and otherwise hasten the appeals process. However, just as consumers must be able to apply online, over the phone, via the mail or in-person, all of these methods of appeals should be available.

- *Will the systems have functionality to* ***coordinate the appeals process between Medicaid and the exchange****?* Coordinating the appeals process between Medicaid and the exchange is critically important so that consumers won't have to deal with two agencies on appeals that may involve both Medicaid and coverage under the exchange. When additional federal policy or guidance is finalized, it will be important to further examine how the systems can facilitate the process for consumers and the agencies involved.

Summary

By searching IT-related documents, including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

Other top consumer "Issue Areas" addressed in this series include:

- Will the online application and consumer web-based services be easy to use? (#1)

- How will the system help consumers with special circumstances, such as immigrant families and children with divorced or absent parents? (#2)
- How will the website facilitate access to personalized help from the call center, navigators, or other assisters? (#3)
- How will the IT system use electronic data sources to verify eligibility in real-time? (#4)
- Will the web-based services help consumers compare, make an informed selection and enroll in a health plan of their choice? (#5)
- How will the IT infrastructure coordinate coverage seamlessly between an exchange, Medicaid, and CHIP? (#6)
- How will the system help people maintain and renew coverage? (#7)
- How will the system protect the privacy and confidentiality of personal information? (#8)
- What data will the system generate to evaluate program performance and consumer satisfaction? (#10)

Authors: Tricia Brooks, Georgetown Center for Children and Families, and Julie Silas, Consumers Union

Julie Silas, Senior Health Policy Analyst at Consumers Union, served as a consultant on this project. Consumers Union, the policy and advocacy division of Consumer Reports, is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves.

The authors would like to acknowledge the guidance and direction offered by Byron Gross of the National Health Law Program (NHeLP) and Jocelyn Guyer of the Georgetown Center for Children and Families on the design of this project. A special thanks for their helpful feedback goes to our reviewers: Kate Black of the Center for Democracy and Technology, Adela Flores-Brennan of the Colorado Center on Law and Policy, Mary Lou Fox of the Maryland Women's Coalition, Shelby Gonzales of the Center for Budget and Policy Priorities, Daniel Gross of Northwest Health Law Advocates, Martha Heberlein of the Georgetown Center for Children and Families, Elizabeth Landsberg of Western Center on Law and Poverty, and Anna Odegaard of SEIU Healthcare Minnesota.

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Endnotes

[1] 45 CFR 155.205 (d) Consumer Assistance. The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.

[2] For a series of recommendations from state advocates in New York on how to build a robust consumer protection and appeal system to govern exchanges, see "Optimizing Consumer Protections in State Health Insurance Exchanges," Community Service Society (October 2012).

[3] For a comprehensive guide to Medicaid appeals, see A Guide to the Medicaid Appeals Process, Kaiser Commission on Medicaid and the Uninsured (March 2012).

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit Issue Area #10

What data will the system generate to evaluate program performance and consumer satisfaction?

Streamlined, seamless access to expanded and more affordable health coverage options is a primary goal of health care reform. Harnessing and maximizing the use of technology will be critical to achieving the vision of an easy-to-use web-based service that allows consumers to apply for coverage, compare and select plans, and manage their "accounts." Equally important, these new or updated systems will make government work more efficiently and cost-effectively. They will often replace decades-old technology and ameliorate a number of the administrative shortcomings associated with public coverage (such as processing delays and lost paperwork). Many critical policy decisions will be made as these systems are designed and built. As such, they represent an important opportunity for advocates to put forward and win important consumer protections.

To help advocates prepare for this task, we have created "Eligibility and Enrollment Systems: An Advocate's IT Toolkit." An overview brief in the toolkit provides key background information and highlights ten top consumer issues associated with IT system design. This document in the series focuses on issue area #10 — ensuring that web-based services **collect and report information to policymakers and the public.**

The IT system should collect and report data to evaluate program effectiveness and identify opportunities for improvement.[1] In addition, data are particularly important for detecting and addressing health disparities. How the system tracks and reports vital measures of enrollment and retention, how the system promotes transparency so that information is accessible to consumers and stakeholders, and what mechanisms are in place to assess customer satisfaction with the eligibility and enrollment features of the website are key to determining whether the system supports a robust evaluation and ongoing improvement program.

When looking at this issue area, advocates should review documents or ask project staff to answer these questions:

- *What data will the system capture and track to* ***evaluate outreach and how the application process is working****?* A high performing system starts with assessing how well the application process and real-time eligibility are working.
    - Will the system **track the method of application**? Tracking the method of submission (e.g., online, over the phone, by assister) is useful for a number of purposes, such as staffing call centers and evaluating navigator and assister programs.

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- Will the system **identify how an applicant learned about the expanded coverage options** or what led them to apply? While separate studies can be conducted to evaluate the effectiveness of various outreach and marketing strategies, the online system can also be used to capture these data.
- What is the **disposition of applications**, including those abandoned before completing the process? Identifying denials for non-eligibility related reasons is particularly important. Since states are required to rely on electronic verification sources, knowing to what extent applicants are denied coverage for not submitting documents could provide helpful information about the availability and usefulness of electronic data. Additionally, assessing and analyzing where consumers abandon the application process, including demographic details, can point to areas where system improvements are needed.
- What is the **lapsed time between application and eligibility** decision? With a vision of real-time eligibility determinations, it is important to assess how close the system is to achieving this goal and to identify unique characteristics of applications that require more time so that steps can be taken to improve timeliness.

- *How will the IT system* ***collect data and produce reports on key consumer-based measures of enrollment****?* Collecting, analyzing, and acting on enrollment data are critical to measuring progress toward a number of health reform goals, while providing performance metrics that will help identify system issues and program effectiveness.
  - Does the system provide the ability to **break down key enrollment data geographically and demographically**? By comparing enrollment demographics to those of the uninsured, states can better plan their outreach and marketing strategies to reach populations who remain uncovered.
  - Will the system track and report **disenrollment activity** disaggregated by reason, including transfers from one insurance affordability program to another? Of particular importance will be tracking disenrollment due to nonpayment of premiums to assess affordability related issues.
- *Does the system collect and report data on the* ***preferred languages*** *of applicants and enrollees, as well as people with disabilities who need* ***special communications assistance****?* Collecting these data may point to additional language translations or enrollment supports needed by consumers.
- How will the system **track and report key retention data**? Churn in public programs is administratively costly, results in gaps in coverage that impact health outcomes and costs, and makes it difficult to measure the quality of health care.
  - Will the system report the overall **retention rate** as well as the **disposition or outcome of eligibility determinations at renewal**? To improve retention, the IT system will need to not only assess the overall retention rate but also analyze the reasons for non-renewal, especially those not associated with eligibility (such as non-payment of premium). Analysis of these data, including assessing

corresponding gaps in coverage, will help focus attention on ways to improve retention.

- Will the system **report data on renewals**, including a breakdown by method of renewal such as automatic renewals, online, over the phone, etc.? Will renewal data be broken down geographically and demographically? Such data will help assess if specific groups are finding it more difficult to retain coverage and is vitally important for addressing health disparities.

- *Will the IT system be used to administer **routine surveys of customer satisfaction** with the eligibility and enrollment portions of the website?* The system offers a number of opportunities for states to seek consumer feedback. For example, after the application is complete, consumers could be asked if they want to complete a short survey on their experience using the website. The system also is a great resource for providing links to more comprehensive surveys that assess not only the customer experience in the application and enrollment process, but also satisfaction with QHPs and Medicaid managed care plans. No matter how customer satisfaction with particular plans is assessed, it is important for such information to be posted on exchange websites for consumers to review as they compare and select plans.

- *How will the system report the key enrollment and timeliness **data to promote transparency** in program performance?* Outdated eligibility and enrollment systems have inhibited the ability to capture data needed to monitor performance and identify opportunities for improvement.[2] In providing substantial financial support for new IT systems, the federal government has signaled its intent to establish a set of standardized performance metrics that will aid states in evaluating the effectiveness of their publicly-supported programs.[3] The data should be shared publicly on a routine basis.

- *Does the state plan to collect and report other types of data that can provide additional insight into how health reform is working?*

    - Will the system **aggregate and report data on requests for an exemption from the requirement to have health insurance,** including approval rates and reason for exemption?

    - Will the system **aggregate and report data on appeals and grievances**, including reasons and disposition?

    - How will the system **display QHP quality ratings**? Exchanges are required to provide information to consumers on the quality ratings of plans. It will also be useful for states to do the same for Medicaid managed care plans.

Summary

By searching IT-related documents, including analyses of existing systems or Requests for Proposals (RFPs), advocates can learn much about how their state is approaching the design of their new systems. When information is not readily available, advocates should request a meeting

or submit questions in writing to help ensure that consumers' needs are foremost in the minds of IT developers and agency administrators when making technical and policy decisions about Medicaid and, if applicable, state-based exchange IT systems. Ask your state, including possibly its IT vendors, to create or otherwise participate in an ongoing consumer engagement process in which advocates can connect with policy staff and IT experts as key design decisions are being made and implemented. Such a consumer engagement process is likely to provide the most meaningful opportunity to ensure that the IT system created to implement the ACA's requirements achieves its goal of streamlined, simplified access to coverage.

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Endnotes

[1] For more information on using data to assess program performance, see these reports:

M. Harrington, C. Trehnold, A. Snyder, "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance," Robert Wood Johnson Foundation (November 12).

C. Trenholm, M. Harrington, A. Snyder, A. Weiss, "Using Data to Drive State Improvement in Enrollment and Retention Performance," Robert Wood Johnson Foundation (November 2011).

T. Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown Center for Children and Families (January 2009).

[2] J. Hudman, C. Trenholm, S. Artiga, "Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-Offs to Consider," Kaiser Commission on Medicaid and the Uninsured (December 2011).

[3] For more information on system performance measurement, see "Guidance for Exchange and Medicaid Information Technology (IT) Systems," Version 2.0, May 2011 at http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf

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Eligibility & Enrollment Systems: An Advocate's IT Toolkit

Glossary, Key Terms and Acronyms

Advance Planning Document (APD) – is a process the Department of Health & Human Services (HHS) uses for federal review, approval, and funding of information systems supporting the operation of federal programs, including Medicaid. States complete an APD template to: 1) describe in broad terms their plans for managing the design, development, implementation, and operation of a system that meets federal, state, and user needs in an efficient, comprehensive, and cost-effective manner; 2) establish system and program performance goals in terms of projected costs and benefits; and 3) secure federal financial participation (FFP) for the state.

Advanced Premium Tax Credit (APTC) – The Affordable Care Act (ACA) establishes refundable premium tax credits to help make health insurance more affordable to lower-and middle-income individuals without access to affordable employer-sponsored health insurance or other forms of "minimum essential coverage." Under the ACA, individuals eligible for the premium tax credit must have annual incomes between 100 and 400 percent of the federal poverty level (FPL); tax credits are also available for legal immigrants with incomes below 100 percent of the FPL who are not eligible for Medicaid. The refundable premium tax credits are available for the purchase of health insurance coverage offered through health insurance exchanges. Eligible individuals can opt to use the tax credit in "advance" to reduce the amount of the premium they pay for health insurance, making the monthly costs more affordable.

Artifact – In the context of IT, an artifact is one of many kinds of tangible by-products produced during the development of software. Some artifacts (e.g., business requirements and design documents) help describe the function, architecture, and design of software. Other artifacts are concerned with the process of IT development itself, such as IT Gap Analyses, project plans, business requirements, or risk assessments.

Audio Visual Application Assistance (AVAA) – This technology features computer-facilitated interactive audio and video capacity. It can be offered in multiple languages and is intended to lower barriers to applying online due to language, literacy, or disability.

Audit Trail - A historical record showing who has accessed a computer system and what operations were performed. Audit trails are useful both for maintaining security and recovering lost transactions.

Batch Process – Batch processing occurs when multiple requests for information are batched and requested at the same time. For example, most states verify citizenship through the Social Security Administration (SSA) using a daily batch process. Data for all new applicants are combined into a batch and transmitted to the SSA, instead of executing an immediate look-up or request for data on an individual basis. Batches can be submitted periodically but are often done daily, weekly or monthly, depending on the task.

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Business Requirements Document (BRD) – The BRD is one of the key documents that defines the responsibilities and expectations of an IT design vendor. It describes the activities that must be performed to meet the organizational objectives. The BRD includes conditions and terms, and spells out customer (i.e., the Medicaid agency or exchange) needs and expectations.

Cache – In computer science, cache is a component that transparently stores data so that future requests for that data can be accessed faster.

Center for Consumer Information and Insurance Oversight (CCIIO) – CCIIO is one of six centers within CMS. It is charged with implementing many provisions of the ACA, specifically the provisions related to private insurance and consumer assistance. CCIIO has direct responsibility for development of the federally-facilitated exchange and oversight of state-based exchanges.

Center for Medicaid and Medicare Services (CMS) – CMS is the agency of the U.S. Department of Health and Human Service (HHS) that administers Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). CMS directly administers Medicare and works in partnership with state governments to administer Medicaid and CHIP.

Center for Medicaid and CHIP Services (CMCS) – CMCS is one of six centers within CMS. It serves as the focal point for all national program policies and operations related to Medicaid and the Children's Health Insurance Program (CHIP).

Chat – Online or e-chat refers to communication over the Internet that offers a real-time direct transmission of text-based messages from sender to receiver. Chat has become a popular technology-based tool to provide customer service to individuals using web-based services.

Co-Browsing – Is a system tool that allows customer service or help desk staff to view the same screen, at the same time, as the applicant. This is a useful feature when consumers have a problem that helps support staff discern if there is a system issue (i.e., I can't get to the next screen) or the consumer needs clarification of what information to provide (i.e., who do I include in my household?).

Collaborative Application Lifecycle Management Tool (CALT) – The CALT is a collaborative tool that creates a centralized repository for storing, collaborating on, and sharing deliverables and artifacts from IT projects in support of Medicaid administration and establishment of exchanges. Within the CALT, CMS has created the Medicaid State Collaborative Community to allow States the opportunity to leverage, share, and collaborate on Medicaid information technology (IT) systems development projects and to submit artifacts to the CALT for review and approval as required by the systems development lifecycle (SDLC) process.

Cost Allocation Rules – Establish the principles and standards (detailed in OMB Circular A-87) to provide a uniform approach for allocating costs among programs that benefit from a shared system or service. While eligibility and enrollment systems costs must still be allocated between Medicaid, CHIP, and the exchange, the federal government has approved a temporary exception to cost allocation as it applies to other human service programs (including, but not limited to, Temporary Assistance for Needy Families (TANF), Child Care and Development Fund (CCDF), and the Supplemental Nutrition Assistance Program (SNAP)). Because other federally funded human

services programs can benefit from the changes being made to create a modern infrastructure to determine eligibility for exchanges, tax credits, Medicaid and CHIP, this time-limited waiver allows states to reuse these assets for other programs and purposes without having to allocate a proportional share of development costs to the other programs. Incremental costs for additional requirements needed for the inclusion of other programs, whether they are added to those projects at initial or later stages, must be charged entirely to the benefitting program.

Cost-Sharing Reductions (CSRs) – In addition to APTCs, consumers with income up to 250 percent of the FPL will qualify for lower maximum out-of-pocket health care costs charged as deductibles, co-payments, and co-insurance when they receive health care services.

Commercially Available Off-the-Shelf (COTS) – The term COTS is associated with acquisitions of products that are commercially available, usually software pre-designed for a specific function. Many IT system upgrades or enhancements propose to use COTS, alongside custom-designed components, to save time and money. While generally a finalized product, some COTS software may offer certain flexibility for customization.

Dynamic Questioning – This approach to an online application uses internal system rules to skip questions that are not relevant to the user based on information previously entered. For example, if an applicant indicates they have no dependents, the system will not request additional information such as name, gender, birthdate, and social security number of dependents, but rather skip those follow-up questions. Dynamic questioning will reduce the amount of information asked of consumers and make the application process more straightforward and streamlined. When dynamic questioning is used, the order or sequencing of requested information matters and should be given careful consideration in the IT design phase.

Early Innovator Grants – In 2009, CMS released a funding opportunity for up to five states to be the first to develop exchange IT systems. Ultimately, seven grants were awarded, but only four states have moved forward with early system development: Maryland, New York, Oregon, and a consortium of New England states. A primary goal for the innovator states is to share lessons learned and offer an inventory of artifacts and products that can be adopted and adapted for use in other states.

Electronic Account – An electronic case file will be created for applicants and enrollees that includes all the information provided by the applicant, electronic verifications, eligibility determinations, enrollment information, notices, and notes from the discrepancy resolution process. Regulations require states to electronically transfer accounts between programs to provide seamless coordination for all insurance affordability programs.

Eligibility Rules Engine – The eligibility rules engine is the component of the IT system that includes all the rules regarding eligibility (e.g., whose income and what income counts, who is considered a member of the household, etc.). This is the "brains" of the IT system that will examine data submitted by applicants, as well as electronic sources of verification, and apply the business rules written into the system to determine eligibility.

Enroll UX 2014 - Enroll UX 2014 is a website portal template that establishes a new standard for public and private health insurance enrollment and provides a design reference for states and federal health insurance exchanges. A public-private partnership between eight national and state

foundations, the federal government, and 11 states collaborated on the design of Enroll UX 2014. It is available for every health insurance exchange, including the federally-facilitated exchange, to incorporate, in whole or in part, in its IT system design.

Exchange Blueprint – This document includes the declaration letter and application form, which a state must submit to CCIIO if it elects to operate a state-based or partnership exchange. The application part of the Blueprint is essentially a checklist of the activities and characteristics of an exchange, including legal authority and governance; consumer and stakeholder engagement and support; eligibility and enrollment; plan management; risk adjustment and reinsurance; the SHOP (small business) exchange; organization and human resources; finance and accounting; technology; privacy and security; oversight, monitoring, and reporting; and contracting, outsourcing, and agreements.

Federal Data Services Hub – The federal hub will facilitate access to electronic data, through a single point of entry that is needed to verify income; incarceration, citizenship and immigration status; and other information pertinent to eligibility in Medicaid, CHIP, or an exchange. State IT systems will be required to interface with the federal data services hub to access key federal eligibility-related data from the Internal Revenue Service, the Social Security Administration, the Department of Homeland Security, and more.

Federally Facilitated Exchange (FFE) – The ACA established new private health insurance marketplaces called health insurance exchanges that will exist in every state. Each state has the option to establish and manage its own state-based exchange. In states that do not establish a state-based exchange, the federal government will operate an exchange, known as the FFE. In the FFE, states may choose to keep control over plan management and/or consumer assistance, which is referred to as a partnership exchange.

Federal Financial Participation (FFP) – The FFP is the share of eligible or qualified costs that the federal government will pay for a state's Medicaid costs, including administrative services and IT systems. The federal rate or share may vary by state or expense category. States developing eligibility and enrollment IT systems that meet federal standards are eligible for a 90% FFP through 2015, compared to the standard 50% FFP. Ongoing maintenance and operating costs for qualifying systems are eligible for a 75% FFP (also increased from the standard 50%).

Federal Funding Opportunity Announcement (FOA) - A FOA is a notice announcing a federal grant funding opportunity. FOAs can be found at Grants.gov/FIND and each includes instructions, a Grant Application Guide, and a Grant Application Package. The website lets organizations apply for grants for over 1,000 grant programs from 26 federal agencies.

Functional Requirements – In software engineering, a functional requirement defines the function or purpose of a software system or its component. The functional requirement describes the "result" required of an IT system or component.

Gate Review – Gate reviews are a tool used by CCIIO and CMCS to review project progress and validate that the project is ready to move to the next phase. Gate reviews consolidate exchange and Medicaid eligibility and enrollment IT system development into a single review process. The gate reviews help map development activities and trigger the release of funds as states hit required benchmarks. In exchange agreements, the process for review is known as a Systems

Development Life Cycle (SDLC), which explicitly consolidates review of Medicaid and exchange IT system development.

Health Information Exchange (HIE) – The mobilization of health care information electronically across organizations within a region, community, or hospital system is known as HIE. It provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged.

In-Person Assistance – Exchange establishment grants can be used for states to develop and fund a consumer assistance program (distinct from the navigator program) that provides in-person assistance to consumers seeking coverage through the insurance affordability programs.

Insurance Affordability Programs – Medicaid, CHIP, and coverage subsidized by advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs) in the exchanges are collectively referred to as the "insurance affordability programs."

Interactive Voice Response System (IVR) – IVR is a technology that automates interactions with telephone callers. Historically, IVR solutions have used pre-recorded voice prompts and menus to present information and options to callers with responses entered through a touch-tone telephone keypad. Modern IVR solutions also enable input and responses to be gathered via spoken words with voice recognition. IVR technology is one mechanism by which states can record voice signatures that are stored as electronic files (similar to music files on an MP3 player) in the consumer's electronic account.

Interface – An interface is a tool and concept that refers to a point of interaction between components, and is applicable at the level of both hardware and software. This allows a component, whether a piece of hardware such as a keyboard or a piece of software such as an Internet browser, to function independently while communicating with other components. Consumers use interfaces through their own computers to perform actions over the Internet such as online banking or making purchases.

Integrated Eligibility System (IES) – An IES is used often to refer to a single, streamlined eligibility and enrollment system for different public coverage programs. As envisioned under the ACA, an IES determines eligibility through an online process for eligibility and enrollment in all insurance affordability programs.

IT Gap Analysis – An IT Gap Analysis is a process that examines the current state IT infrastructure and identifies gaps or functionality that is needed to achieve the objectives of a streamlined, simplified eligibility and enrollment system. It shows the lineage between "as is" (what the system is today) and "to be" (what the end result of the IT infrastructure is expected to be). Undertaking an IT Gap Analysis helps a state determine how best to move forward; whether developing a new, or upgrading an existing IT system.

Joint Application Design (JAD) – JAD sessions are a technique or set of techniques used to gain more rapid consensus from a group of individuals during the design phase of IT system development. The JAD technique can be applied to a wide variety of areas where consensus is needed. This includes gathering business requirements, creating a project work plan, developing software, building a quality management plan, and so on.

Medicaid Eligibility and Enrollment Systems Advance Planning Document (E-APD) - Provides an expedited checklist for Medicaid Eligibility & Enrollment Systems specifically to support states when requesting CMS review and prior approval to receive enhanced FFP for Medicaid IT system(s) projects related to eligibility and enrollment functions.

Medicaid Information Technology Architecture (MITA) – MITA is framework intended to foster integrated business and IT transformation across Medicaid to improve the administration of the Medicaid program. State technology, funded through federal dollars, is expected to meet the MITA standards that establish national guidelines for technologies and processes that can enable improved Medicaid program administration. The MITA initiative includes an architecture framework, processes, and planning guidelines for enabling state Medicaid agencies to meet common objectives within the framework while supporting unique local needs.

Medicaid Management Information System (MMIS) – The MMIS is an integrated group of procedures and computer processing operations (subsystems). For Medicaid purposes, the MMIS system is comprised of "mechanized claims processing and information retrieval systems" but, in layman's terms, is often called the claims processing or payment system. MMIS systems have qualified for higher FFP than eligibility and enrollment systems until the 90/10 rule extended the definition of mechanized "claims" to "claims of eligibility," thereby extending the 90% FFP to eligibility systems.

Modified Adjusted Gross Income (MAGI) – MAGI is the income standard adopted under the ACA to determine eligibility for advanced premium tax credits, cost-sharing subsidies, and most, but not all, categories of Medicaid coverage. In the context of the ACA, MAGI is not a number pulled from your federal tax return. It is a formula or methodology for calculating income.

Navigator – Exchanges are required to have a navigator program that will provide grants to qualified organizations to conduct outreach and assist consumers in applying for and enrolling in an insurance affordability program. Development costs for the navigator program can be funded through a state's exchange establishment grant, but grants to pay for navigator services must come from other state sources.

Open Source Software – Computer software that makes the source code available and certain rights, normally reserved for copyright holders, open for public use. Open source software permits users to study, change, adapt and improve existing software products. Software products developed with public funds often fall under this definition.

Portal – The portal will provide access to online services, including the ability to search for information, for consumers, as well as navigators, providers and others to use for various purposes. The portal may be referred to as a web portal, consumer portal or health care coverage portal. In particular, the portal allows direct input by consumers and interfaces with other systems to populate the single, streamlined application.

Post-Eligibility Verification – This method of eligibility verification, currently in place in Oklahoma's system, makes a preliminary eligibility decision based on information provided by the applicant. After enrollment, the system checks other sources of data to confirm ongoing eligibility.

Project Management Office (PMO) – The job of this team is to document, guide and develop standards and metrics for a project. Some states are hiring separate vendors to take on the PMO responsibilities during the development of IT systems for health insurance exchanges.

Qualified Health Plan (QHP) – Under the ACA, starting in 2014, a QHP is a private insurance plan that is certified and marketed by an exchange. Each QHP must provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.

Real-Time Eligibility – High performing IT systems will allow consumers to apply for coverage while the system verifies eligibility using electronic sources of data. Real-time eligibility occurs when the system delivers an eligibility decision immediately or shortly (within minutes) after the consumer submits the application as complete.

Reasonable Compatibility – This is a new term of art introduced in the regulations implementing the ACA. In verifying eligibility, states must rely, to the maximum extent possible, on electronic data obtained from trusted third party data sources before requesting documentation from applicants and beneficiaries. Additional information, including documentation, may be requested from individuals only when information cannot be obtained through an electronic data source or is not ''reasonably compatible'' with information provided by the individual. For exchanges, electronic data are considered "reasonably compatible" with an applicant's self-supplied information if the differences or discrepancies do not impact the eligibility of the applicant, including the level of APTC's or cost-sharing reductions. For Medicaid, information obtained through an electronic data match shall be considered reasonably compatible with information provided by or on behalf of an individual if both are either above or at or below the applicable eligibility income limit or other relevant income threshold, such as premium levels. States are responsible for further defining "reasonable compatibility."

Request for Information (RFI) – RFIs are often used to solicit information from prospective vendors that may be used to inform or develop a formal request for proposals (RFPs).

Request for Proposals (RFPs) – RFPs are official documents released to potential bidders who are asked to respond with a proposal for a project or grant. Most of the time they define the scope and parameters of a project, including the expected budget. RFPs are often required to meet state competitive bidding or procurement requirements.

Seamless Coordination – Agencies operating an exchange and administering Medicaid and CHIP are expected to coordinate coverage between programs in a way that is seamless or invisible to consumers. This includes transferring the consumer's electronic account to appropriate agencies so that consumers are not required to provide duplicate information.

Self-Attestation – Self-attestation allows applicants to provide information and attest to its accuracy, rather than verifying data through other sources. Self-attestation is permitted for all factors of eligibility, except as required by law (i.e. citizenship and immigration status). States must accept self-attestation of pregnancy, unless the information provided is not reasonably compatible with other information in the state's files.

Shared Eligibility Service - CMS defines an eligibility service as a set of IT functions that produce an eligibility determination based upon modified adjusted gross income (MAGI). The service incorporates an application, a set of verifications (for citizenship, income, residency, etc.) and business rules that together determine how much financial assistance a consumer should receive in paying for affordable health insurance. A shared eligibility service is not necessarily the same as one system.

State-Based Exchange - The ACA establishes new private health insurance marketplaces called health insurance exchanges. Each state has the option to establish and manage its own state-based exchange (SBE) that meets certain minimum federal standards. In states that do not establish a SBE, the federal government will operate an exchange know as the FFE.

State Data Services Hub – States may choose to create and operate a state hub, similar to the federal HUB, which will provide a single point of access to multiple databases. Several states already have state data services hubs, such as Utah's eFind system.

Systems Development Life Cycle (SDLC) - Is a conceptual model used in project management that describes the stages involved in an information system development project, from an initial IT Gap Analysis through design, development and deployment to maintenance of the completed application. This process is incorporated into "gate reviews" for such items as business service descriptions, requirements specifications, system design specifications, and more.