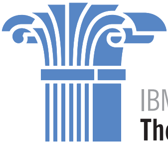

IBM Center for
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UNIVERSITY OF MARYLAND
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IMPLEMENTATION BRIEF

Implementation of the Affordable Care Act of 2010

Modernizing Medicaid: Strategies for Managing Enrollment in Health Care Reform

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The Patient Protection and Affordable Health Care Act was signed into law in March 2010. Shortly after the passage of the bill, the University of Maryland School of Public Policy and the IBM Center for the Business of Government came together to create a Blog on the IBM Center's website to address implementation issues surrounding the new law.

The Making Health Care Work Blog focused on the central challenge of the new law: How will the nation implement the massive bill of over 2700 pages? The Blog discussed how the nation can make health care reform work, as well as the challenge of designing important new tools needed for government. While news coverage focuses on the politics of health care reform in Washington, the Blog went beneath the rhetoric to share the difficult details of what states and federal officials have to do to make sure that the law works on the ground.

From analysis to "Q and As" with top officials, the Making Health Care Work Blog remains a source of valuable information about Medicaid expansion, health insurance exchanges, and other top challenges in the implementation of health reform.

Review the discussion at:
**www.businessofgovernment.org/blogs/
making-health-care-reform-work**

Now that health reform has been enacted and signed into law, the nation needs to start asking: How are we going to make this work? Though battles are still raging over provisions in the final bill (e.g. the constitutionality of individual mandates), people have begun to turn their attention to the details of implementing the new law.

Jonathan D. Breul

The University of Maryland School of Public Policy and the IBM Center for the Business of Government are collaborating to offer a unique voice on the major implementation issues surrounding the law. We're operating with two driving ideas:

- The battle over the passage of health reform was just the prelude to even bigger implementation battles to come.
- Making health reform work is the next great frontier, and we all have a vested interest in understanding the complicated process of turning legislation into a national program that is implemented in a way that works for us all.

Donald F. Kettl

This Implementation Brief, *Modernizing Medicaid: Strategies for Managing Enrollment in Health Care Reform,* focuses on the process of identifying eligible enrollees and presents six promising practices for enrolling more people. The Brief is published at a time when states are grappling with how to reduce spending on Medicaid. In the face of significant budget shortfalls, some states are proposing to drop hundreds of thousands of low-income adults from Medicaid.

The term of art is "implementation," but that doesn't begin to capture the many issues that will arise as government transforms the Act's promise into practice. How do we make sure that those tasked with implementing the reforms and with delivering health care more effectively are able to accomplish what the new legislation demands of them?

This Implementation Brief seeks to contribute to the discussion about the Act's implementation. We welcome your comments and look forward to a lively conversation.

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The purpose of this Implementation Brief is to identify and explain several approaches to maximizing enrollment under the Medicaid expansion provisions of The Affordable Care Act (ACA) of 2010.[1] This major legislation expanded Medicaid to all legal residents of the United States under age 65 with incomes up to 133 percent of the federal poverty line (FPL) beginning in 2014.

Medicaid is expected to add about 16 million people to the program by the end of the decade. The new enrollees are predominantly people made eligible for the first time by ACA, but also include a significant number of people already eligible but not enrolled. An estimated 87.2 percent of all new funding for Medicaid expansion, federal plus state, would be devoted to people newly eligible for Medicaid, with the remainder accounted for by a greater outreach effort to enroll people already eligible.[2]

This Implementation Brief is the first in a series of reports providing specific strategies for implementing various key features of ACA. It focuses on identifying the eligible enrollees and promising practices for getting them into coverage. The next Implementation Brief will focus on best practices in care management for those newly eligible for Medicaid, and the third will address the important challenge of assuring an adequate number and good mix of health care providers to serve the expanded Medicaid population.

The principal audience for this Implementation Brief is agency heads, program managers, and their staff in both federal and state government, along with legislative leaders and their staff. We also hope that people working in the health care system and in the research and policy communities will find this information useful.

The predominant culture over the past several decades for enrolling people into means-tested federal and state government programs has been one in which government agencies require applicants to "prove it to us that you are eligible." This involves lengthy and frequently confusing application forms, considerable documentation requirements (e.g. pay stubs, establishment of residence, citizenship requirements), requiring face-to-face meetings or interviews, and checking and re-checking eligibility at regular intervals.

Historically, the onus of responsibility is mostly on the applicant, and a paper-based system of eligibility system is prevalent. All of this creates substantial barriers to participation, and as a result, many who are eligible are uninsured while others enter the program only to be dropped despite remaining eligible. Some two-thirds of uninsured children are eligible for either Medicaid or CHIP but are not participating. Many

families do not know they are eligible for these programs but others do not apply because it can be time-consuming, confusing, and sometimes demeaning to do so.[3]

In contrast, the newer and more promising approaches highlighted in this Implementation Brief are designed to remove the barriers to enrollment and use 21st century technology to facilitate enrollment. ACA promotes a “culture of coverage” in which the “default option” is getting coverage—from either public or private sources. In place of endless paper trails and a climate of “you prove it to us,” a more advanced approach says “let us use information from our own public sources to see if you likely or almost certainly qualify, and if so, we will notify you, and enroll you (subject to later verification), unless you specifically opt out.” Instead of applicants being active and government passive, the switch is to a government that is active, and applicants are unburdened. A “trust but verify” attitude supplants the “prove it to us” mentality.

Promising Approaches to Maximizing Enrollment

The number of people who actually enroll in the program is by no means a fixed or pre-determined matter. It will depend on the strategies employed to identify and facilitate enrollment of people newly eligible for coverage as well as new ways to promote program participation by those already eligible but not enrolled.

This Implementation Brief describes promising approaches for outreach and enrollment. It is important to recognize that there are countervailing pressures on states that may limit their desire or ability to employ these approaches. States are still experiencing significant budget deficits even as the economy has been gradually recovering from the deep recession.

While the federal government will be paying the full cost of the newly enrolled population for the first three years, declining gradually to 90 percent in 2020, the new law will also draw in people already eligible for Medicaid but not participating, and the state will get its normal federal matching rate for these people—ranging from 50 percent to about 78 percent. In addition, the federal government is pushing for a reduction in errors that in some cases allow a small proportion of people not actually eligible to slip through the system and enroll. States are also now confronted by serious problems related to underfunded pension funds and retiree medical programs for their employees. Against this backdrop, those proposing reforms will have to make a good “business case” for maximizing enrollment through the kinds of approaches proposed here.

APPROACH 1: Helping Insurance Exchanges Direct People to Either Public Programs or Private Coverage Choices

The Affordable Care Act (ACA) calls for the establishment of state-based health insurance Exchanges for individuals and small firms. These Exchanges, which will offer a choice of health plans and sliding-scale subsidies based on income, will be the subject of a subsequent Implementation Brief. An important function of the exchanges will be to develop a kind of clearinghouse that will assess people's eligibility for Medicaid, CHIP—the program for children—and the Exchanges. ACA requires states to create enrollment systems that ensure that applicants are screened for all available subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation requirements from applicants. It further requires states to operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification processes.[4]

The success of Medicaid enrollment will depend in part on the capacity of these Exchanges to perform this clearinghouse function and to make accurate determinations of eligibility for either public programs or the Exchanges. ACA requires Exchanges to affirmatively determine eligibility for Medicaid and CHIP and then to enroll people into the appropriate coverage. Once a consumer files an application with any program, eligibility for *every program* should be determined, without any need for further action by the consumer.[5] Further, states can use data to "pre-populate" application forms. Once consumers provide their name, social security number, and address—where possible online—the Exchange could compile all available data relevant to eligibility, present it to the consumer for confirmation, and grant eligibility accordingly.

The federal government is providing strong financial incentives to the states for these new approaches to eligibility determinations and enrollment. On November 8, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a Notice of Proposed Rulemaking (NPRM) 3 affecting Medicaid reimbursement for eligibility and enrollment systems. The proposed rule would increase the federal matching rate for Medicaid eligibility and enrollment systems. Reimbursement for the design, development, and installation of eligibility and enrollment systems would increase from a 50 percent federal match to a 90 percent federal match, effective through December 31, 2015. The maintenance and operation of such systems would also be eligible for an increased reimbursement rate, from a 50 percent to a 75 percent federal match, which would remain available indefinitely, provided these systems continued to meet other requirements.

Medicaid eligibility systems will need to be developed in such a way as to allow for both easy adaptation of systems over time and easy adoption of components within and across programs. States may build upon work already completed under the Medicaid Information Technology Architecture (MITA) project in order to have a comprehensive framework that will enable increased sharing of electronic health information across systems. States are encouraged to work collaboratively, sharing and reusing Medicaid technologies and systems that have already shown promise in other states.[6]

APPROACH 2: Promoting Express Lane Eligibility

Express Lane Eligibility establishes connections between Medicaid and CHIP, and other means-tested government programs with similar income eligibility rules, to identify and quickly enroll children. The basic idea is that states would create an "express lane" connecting children enrolled in programs such as federal nutrition programs that carries children directly into Medicaid or CHIP, with later verification. The major programs to which Medicaid and CHIP could be linked are the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the National School Lunch Program (NSLP). A report by Stan Dorn of the Urban Institute highlights strategies that states may employ to create express lanes that augment enrollment in Medicaid or CHIP:[7]

- States can automatically find a child eligible for Medicaid or CHIP based on gross income or adjusted gross income shown on the family's state income tax form.
- Children receiving Food Stamps can automatically meet Medicaid eligibility requirements. In fact, only 0.1 percent of uninsured children meeting Food Stamp eligibility standards live in families with income that is too high for Medicaid or CHIP. Thus, using Food Stamp eligibility to automatically enroll children in one of these programs is almost certain to be an accurate eligibility determination.
- Children receiving free school lunches can automatically be found eligible for Medicaid or CHIP. While the match in eligibility between NSLP and the health care programs is not as near-perfect as it is with Food Stamps, 96 percent of the children getting free school lunches live in families with incomes that qualify them for Medicaid or CHIP.
- States now have the option of documenting citizenship and identity by presenting the Social Security Administration (SSA) with a child's name and Social Security number. Citizenship is established if SSA determines that its files do not contain any information inconsistent with citizenship.
- Under ACA, many of these approaches could be employed by states and the federal government to enroll both children and adults in public programs.

APPROACH 3: Using Information from Income Tax Filings to Determine Program Eligibility

Another way to identify people who are eligible for Medicaid and CHIP involves using forms from state or federal income tax filings to identify people who are likely to be eligible. Under ACA, federal, rather than state income tax data will now be central to eligibility determination for subsidies in the Exchanges. ACA seems to give states the authority to do the same with Medicaid.

ACA can be read to permit states to use prior-year tax data to qualify adults and children in Medicaid as has been done in the past. New York, for example, uses such tax returns during the first three months of the year, and other states could do the same. In later months, states could supplement tax data with more recent income information, such as that from new hires data bases. Also, states could present consumers with whatever data they have at the point of eligibility determination and ask consumers to confirm the data's continued accuracy.[8]

In addition, the following approaches could also be undertaken:

- States could use their own income tax forms, and/or work together with the federal government using federal income tax information, to increase enrollment among people newly eligible for Medicaid. Clearly, assuring privacy is a top priority.
- Taxpayers could be required or allowed to identify their uninsured household members and indicate on the tax forms whether they would permit the federal government and the states to use this information in determining eligibility for Medicaid and subsidies in the Exchange. For example, when people file state income taxes electronically, a prompt could allow them to give the state permission to transfer information from the tax forms to an on-line application for Medicaid or to the Exchange, where eligibility for all subsidies could be determined.
- States could use income data from tax forms to inform people that they appear to qualify for Medicaid or subsidies in the Exchange, and provide them with a toll-free number to request coverage, confirm eligibility, and select a health plan (or authorize the state to select one for the consumer).[9]

APPROACH 4: Improve Retention of People Enrolled in Medicaid and CHIP

In addition to facilitating enrollment of children and adults “at the front end” of Medicaid coverage, an important challenge is to retain people in Medicaid as long as they remain eligible. Poor retention of both children and adults is an important, and frequently overlooked, cause of children and adults being uninsured. A recent study by Professor Benjamin Sommers shows that among children who were *eligible for Medicaid or CHIP but uninsured* in 2008, more than one-third, or 35.5 percent, had been enrolled in Medicaid or CHIP the previous year—28.6 percent in Medicaid and 6.9 percent in CHIP—and were still eligible but not enrolled.[10] Many of these children were dropped from coverage through the recertification process.

- To enhance retention of people enrolled in Medicaid and CHIP, states may use 12-month continuous eligibility. Continuous eligibility means that states would redefine the eligibility determination process from a month-to-month basis to an annual basis. At least 20 states have implemented this strategy for children and New York has just adopted it for adults. In effect, a person would be granted a year of coverage, irrespective of monthly income fluctuations. While this step would reduce the problem of eligible people losing public coverage, it could also augment the problem of people remaining in public coverage even though they have become ineligible.

- Continuous eligibility should lead to substantial administrative savings by reducing “churning” in and out of Medicaid and CHIP. Louisiana uses data to renew coverage without contacting the family when such data show that continued eligibility is reasonably certain. When data are not sufficient to establish eligibility, families are encouraged to provide missing information by phone. Only if all else fails must families complete paperwork documenting continued eligibility. As a result, fewer than 1 percent of children experience procedural terminations at renewal.

- Continuous eligibility would address the very significant problem of large numbers of people losing Medicaid coverage during the year, despite actually remaining eligible. This loss of Medicaid and CHIP coverage has various serious adverse health consequences.[11] Ku and colleagues found that “Many chronic diseases, such as diabetes, asthma, or chronic obstructive pulmonary disease, can be effectively treated with primary medical care, including regular use of appropriate medications such as oral diabetes drugs or steroid inhalers for asthma. Such diseases are considered ‘ambulatory-sensitive’ conditions because they can be controlled through appropriate ambulatory (office-based) primary care.[12]”

- When these diseases are not well controlled, they can lead to expensive emergency room visits or even hospitalizations. Research has shown that, for both adults and children, interruptions in Medicaid coverage can lead to significant increases in hospitalizations for ambulatory-sensitive conditions.[13] The authors also note that continuous Medicaid coverage can lead to earlier identification of cancer and improved outcomes. Continuous coverage led to an increased incidence of screening for breast cancer and cancer patients enrolled in Medicaid before their cancer diagnoses lived longer than those who enrolled only after diagnosis.[14]

APPROACH 5: Employing Presumptive Eligibility and Related Measures

Presumptive eligibility is the practice of granting provisional eligibility immediately upon receiving an application for enrollment in Medicaid, with later verification. Presumptive eligibility is based on a determination that in all likelihood, this person is eligible, so let's put them in right away, rather than risk losing them under a long review process. Presumptive eligibility has been used to enroll children and pregnant women, but under ACA all hospitals participating in a state Medicaid program can grant presumptive eligibility to all Medicaid populations, including adults, effective January 1, 2014.[15]

Certain "qualified entities" can make preliminary, or "presumptive" determinations that a child is eligible for Medicaid based on the family's declaration that its income is below the state's Medicaid income eligibility guidelines. No verification of income is needed at the time the presumptive eligibility determination is made. Thus, the qualified entity—which includes hospitals, pediatricians, health professionals working at community health centers, and staff of school-based health programs that receive Medicaid reimbursements for health services provided to students—can provisionally enroll the child in Medicaid. The child's parent has until the end of the next month to submit a full Medicaid application.[16]

A challenge for states is to assure that when entities such as hospitals or clinics presumptively enroll a person in Medicaid or CHIP, the necessary follow-up will occur to assure that this person is actually enrolled, rather than just a one-time way of getting providers' bills paid for a certain encounter.

Finally, some states have waived the need for face-to-face interviews for eligibility determinations, and also reduced the burden of documentation of eligibility to a reasonable set of requirements.

APPROACH 6: Adding Outreach and Facilitated Enrollment by Government Staff and Community Health Workers

States can form partnerships with community-based organizations to reach out actively to find and enroll people eligible for Medicaid but not yet participating. These include “out-stationing” enrollment workers in places that people normally visit, such as physicians’ offices and clinics, grocery stores, churches, and so on. Some organizations hold “fairs” on a weekend afternoon where people can sign up for public programs.

Enrollment can also be facilitated by using what are called “community health workers” to assist people. These community health workers are people living in the community who are the friends and neighbors of residents, and have their trust.

Even before Massachusetts enacted its own health reform plan in 2006, the state extended grants to community-based organizations—totalling between $2.5 and $3.5 million annually—to support outreach and enrollment efforts. These grants were supplemented by the Blue Cross and Blue Shield Foundation, and were provided to organizations with a long history of working in underserved communities and that had developed strong trust relationships within those communities.

Ranging from $5,000 to $20,000 per organization, these small grants helped develop a cadre of agencies and individuals with deep knowledge of the state’s health coverage programs. The community-based workers were skilled in culturally and linguistically competent strategies for working with diverse, low-income families. This program has been continued under the state’s reform program and has been judged an important factor in helping Massachusetts cover 97 percent of its population.[17]

These workers may start by helping people apply for Medicaid or CHIP, but this is just the beginning. They can also double-check to make sure that the application was approved. Next, community health workers can help people select a community health center or physician practice as a “medical home,” or regular source of primary and preventive care, and further assist them as they make appointments, keep those appointments, and follow up if appointments with their medical home are missed.

States could develop integrated programs of consumer assistance that pull together Medicaid, CHIP, and Exchange administrative funding.

Bringing poor and near-poor people into Medicaid will help an estimated 16 million people obtain improved access to health care and should improve their health. But states will be challenged to identify the newly eligible people and enroll them.

The federal government and the states should work together to use effective strategies for maximizing enrollment of newly eligible people. These include technology-enabled, streamlined, and paperless enrollment and recertification processes, express lane eligibility, using income tax data to identify potentially eligible people, continuous eligibility, presumptive eligibility, and outreach through community health workers.

This set of new strategies should be supported by modern information technology and electronic data sharing across state and federal programs. This is a “smart government” approach to enrolling people into health care programs that will be required if the Medicaid expansion called for under ACA is to be as successful as possible.

1. The Affordable Care Act encompasses both the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, which amended PPACA. http://docs.house.gov/energycommerce/ppacacon.pdf
2. John Holahan and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Kaiser Commission on Medicaid and the Uninsured. May 2010. p. 44. The numbers presented here represent what the authors call a "lower participation rate assumption." Higher figures result from the higher participation rate assumption.
3. Michael Perry, R. Burciaga Valdez and Christina Chang. *Medicaid and Children: Overcoming Barriers to Enrollment.* The Kaiser Commission on Medicaid and the Uninsured. January 2000. www.kff.org/content/2000/2174.
4. "Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges." Kaiser Family Foundation: Focus on Health Reform. August 2010.
5. See ACA. Section 1413.
6. Kaiser Family Foundation. "Building an Information Technology Foundation for Health Reform: A Look at Recent Guidance and Funding Opportunities." http://www.kff.org/healthreform/upload/8132.pdf.
7. Stan Dorn. "Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP." Urban Institute. April 2009. http://www.urban.org/UploadedPDF/411879_eligible_children.pdf
8. Stan Dorn. "Applying 21st Century Eligibility and Enrollment Methods to National Health Care Reform." Urban Institute. December 2009. p. 6.
9. Dorn. "Express Lane Eligibility…" Supra.
10. BD Sommers. Enrolling Eligible Children in Medicaid and CHIP: A Research Update. Health Affairs Vol. 29, No. 7 July 2010:1350-1355.
11. See, for example, Andrew B. Bindman, Arpita Chattopadhyay, and Glenna M. Auerback. "Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory-Sensitive Conditions." Annals of Internal Medicine. 16 December 2008. Vol. 149, No. 12: 854-860.
12. Leighton Ku, Patricia MacTaggart, Fouad Pervez, and Sara Rosenbaum. "Improving Medicaid's Continuity of Coverage and Quality of Care." Prepared for Association for Community Affiliated Plans. July 2009.
13. Ku et al., supra. p. 6.
14. Koroukian SM "Screening Mammography was used more, and more frequently, by longer than shorter-term Medicaid enrollees." J Clin Epidemiol. 2004 Aug;57 (8):824-31; Bradley CJ, Gardiner J, Given CW, Roberts C. "Cancer, Medicaid enrollment, and survival disparities." Cancer. 2005 Apr 15; 103 (8): 1712-18.
15. "Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges." Kaiser Family Foundation: Focus on Health Reform. August 2010.
16. Donna Cohen Ross. "Presumptive Eligibility for Children: A Promising New Strategy for Enrolling Uninsured Children in Medicaid." Center on Budget and Policy Priorities. http://www.cbpp.org/archiveSite/presum.htm
17. Stan Dorn, Ian Hill, and Sara Hogan. "The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage." State Health Access Data Assistance Center (Shadac). November 2009. http://www.urban.org/UploadedPDF/411987_massachusetts_success.pdf.

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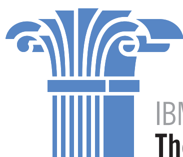

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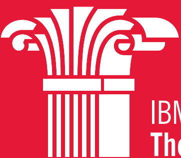

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