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SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform

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Introduction

The Affordable Care Act (ACA) requires that most Americans have health insurance by January 1, 2014. Through an expansion in Medicaid and a system of state-based and federal health insurance exchanges, an estimated 32 million newly eligible individuals will gain coverage under the law.¹ To help achieve this coverage goal, the ACA also includes several provisions that call for major changes in state eligibility and enrollment processes currently used in public health insurance programs (see text box below). The aim is to make enrollment and renewal in Medicaid and exchanges easy, seamless, readily accessible, and consumer-friendly.

Some of the major provisions included in the ACA and subsequent guidance pertaining to eligibility and enrollment include that individuals have a “first class customer experience” comparable to that of major commercial websites such as Amazon; that individuals have multiple ways to apply for coverage (online, by mail or phone and in person); that a single streamlined application can be available to apply for Medicaid, CHIP or exchange coverage; to the extent possible that systems match with other data systems to verify eligibility; and that the most advanced technologies are used in developing these systems.

To a large extent, much of the responsibility for creating these eligibility and enrollment systems resides with the states. This is a tall order, particularly given the short timeframe and, moreover, that many states currently have Medicaid eligibility and enrollment systems that are terribly outdated, with some still relying heavily on paper forms and processes that are not electronically connected to other state or federal programs.²

To help states modernize their eligibility and enrollment systems and bring them into compliance with the ACA, the federal government is making significant funding available to states. A major source is the health insurance exchange planning and establishment grants that, among other things, provide states resources to research and plan for their exchange eligibility and enrollment systems as well as to establish them.³ In addition, in 2011 the federal government awarded “Early Innovator” grants to seven states to design and

1 Congressional Budget Office, 2010, “Health Care: Estimates for March 2010 Health Care Legislation,” <http://www.cbo.gov/doc.cfm?index=11379>, accessed December 2011.

2 Friedman RH. 2007. Medicaid Information Technology Architecture: An Overview. *Health Care Financing Review*, 28(2): 1- 9. Weiss AM and L Grossman. 2011. Paving an Enrollment Superhighway: Bridging State Gaps between 2014 and Today. NASHP, Washington, D.C., June.

3 See, for example, <http://www.healthcare.gov/news/factsheets/2011/01/exchestann.html>;
<http://www.healthcare.gov/news/factsheets/2010/07/esthealthinsurexch.html>

implement IT systems to support their health insurance exchanges.⁴ Another major source of federal funding aimed to help states improve their Medicaid and CHIP IT systems is through the Medicaid Information Technology Architecture (MITA) initiative. Under MITA states can obtain up to a 90 percent matching rate to overhaul or enhance their IT systems.⁵ Given the link between the exchange, Medicaid, and the CHIP programs envisioned under reform, having an up-to-date IT system for these programs is also critical.

In this brief we draw on the experiences of five states—Colorado, Kansas, Minnesota, New York and Oregon—that received federal grant funding from the Health Resources and Services Administration (HRSA) through the State Health Access Program (SHAP). Launched in 2009, before enactment of the ACA, SHAP grants were designed to help states expand health coverage to uninsured individuals using approaches that included community-based outreach and improvements to Medicaid/CHIP eligibility and enrollment processes. (See next section for SHAP details.) We describe the best practices that these states shared with regard to their activities related to outreach, streamlining application and enrollment processes, and modernizing eligibility determination systems; and consider the implications of these practices for implementing the ACA.

Given that Kansas, New York, and Oregon were recipients of three of the seven Early Innovator grants awarded by the federal government to states for IT systems development, our study states include recognized leaders in terms of readiness and ability to develop eligibility and enrollment processes systems that will comply with provisions set out in the ACA. As will be discussed, SHAP funds provided a strong foundation for these states to be selected as Early Innovators.

ACA Requirements for State Eligibility and Enrollment Processes

The ACA envisions a streamlined, simplified, and coordinated system that determines eligibility for and enrolls individuals in all health subsidy programs (including Medicaid, CHIP, and exchange-based premium and cost-sharing subsidies) and that facilitates seamless transitions between programs when necessary. The system should allow for self-service enrollment and renewal and rely on electronic rather than paper-based processes. To meet these goals, the ACA requires states to:

- Create a “no wrong door” system that includes an internet website and that screens people seeking coverage for all health subsidy programs and enrolls them in the correct program.
- Use a single, streamlined enrollment application that allows individuals to apply for Medicaid, CHIP, and exchange-based subsidy programs and that can be submitted online, by mail, telephone, or in person. (The U.S. Department of Health and Human Services is developing an application states can use, or they can create their own.)
- To the maximum extent possible, develop and use secure electronic interfaces to exchange available data to establish, verify, and update eligibility for health subsidy programs.

State exchanges must also establish grant programs to award funding to “Navigators,” that is, trained entities that will provide fair and impartial public education, outreach, and enrollment assistance to consumers.

⁴ For more information on Early Innovator grants, readers are referred to <http://www.healthcare.gov/news/factsheets/2011/02/exchanges02162011a.html>

⁵ Friedman 2007.

The State Health Access Program

Our five study states are part of group of thirteen states that received a grant from the HRSA through SHAP.⁶ SHAP was authorized by the 2009 Omnibus Appropriations Act (PL 111-8). Grants were implemented by HRSA and were designed to help states expand access to affordable health care coverage to uninsured individuals. Though the program’s principle focus was to provide direct funding for coverage of populations not eligible for existing public health insurance programs, states used a variety of approaches to meet the SHAP coverage goal. These included funding community-based outreach grants, creating web-based applications and other efforts to streamline enrollment processes, and modernizing systems that determine eligibility for public coverage programs. For our five study states, eligibility and enrollment process improvements were key components of their SHAP grants.

For the study we conducted site visits to each state between March and August 2011 where we interviewed state officials involved in the SHAP grant generally as well as state enrollment and eligibility and state health information technology (IT) experts, and, in some cases, state IT vendors. We conducted cross-site analyses of study findings to identify common themes, best practices, and lessons learned, and to create this and a complementary brief, *SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform*.

Before presenting study findings, we provide a brief overview of each state’s SHAP grant as it pertains to eligibility and enrollment system improvements.

Summary of SHAP Activities in the Five Study States

Figure 1 presents a summary of study states’ SHAP grant activities concerning outreach, eligibility and enrollment processes, and system improvements.

Figure 1: Summary of Planned SHAP Study States

State (Grantee(s))	Planned Outreach, Eligibility and Enrollment Activities ¹
Colorado <i>State Department of Health Care Policy and Financing</i>	Contract with community-based organizations to conduct outreach and enrollment for coverage programs; develop and implement an online application; create interfaces for electronic verification of information needed to process eligibility; and begin an Express Lane Eligibility program.
Kansas <i>Kansas Health Policy Authority</i>	Place out-stationed outreach and enrollment workers at clinic sites around the state; develop an online application and presumptive eligibility tool; and develop a new modernized eligibility and enrollment system.
Minnesota <i>State Department of Human Services</i>	Develop an online application and create interfaces for electronic verification of information needed to process eligibility.

⁶ SHAP was authorized for up to five years in the Omnibus Appropriations Act (P.L. 111-8). Congress appropriated program funds on an annual basis in federal fiscal years 2010 and 2011 but the program was not funded from federal fiscal year 2012 onward. No-cost extensions have allowed grantees to continue SHAP activities beyond federal fiscal year 2011. For more information about SHAP, see: <http://www.hrsa.gov/statehealthaccess/>, Accessed December 2011.

<p>New York <i>State Department of Health/Health Research Inc.</i></p>	<p>Establish a statewide enrollment center for consumer assistance and renewal processing (via mail, telephone); develop an online eligibility screening tool; and create a more user-friendly interface for eligibility caseworkers.</p>
<p>Oregon <i>State of Oregon</i></p>	<p>Contract with community-based organizations to conduct outreach and enrollment for coverage programs; create interfaces for electronic verification of information needed to process eligibility; hire staff to focus exclusively on eligibility transformation; support Health Insurance Exchange planning; and conduct an evaluation of outreach and enrollment activities (including a state Health Insurance Survey).</p>

Notes: (1) This column shows planned activities, as reported in state’s SHAP grant proposals. Some states were not able to carry out planned activities completely due to grant funding cuts.

Though the five study states’ existing eligibility and enrollment systems are unique, each shares the need for modernization and major improvements to comply with ACA requirements. Systems range in age from seven years (in Colorado) to more than forty years old (in Oregon). All the study states have integrated eligibility and enrollment systems that are used for Medicaid and social services programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). One state, New York, has two eligibility and enrollment systems serving different parts of the state (upstate and New York City).

Each of the states but Kansas had a county-administered Medicaid program, though New York recently announced plans to transition to a state-administered program, contributing added complexity to updating its systems. All five states relied on paper-based application processes, for instance requiring signed paper



application and renewal forms, or hard copy documentation of income and citizenship/residency. Though some of the study states previously established electronic data verification interfaces, these were done on a batch-file basis and could not be used to verify information in “real time.” In total, when the states began modernization, their existing eligibility and enrollment systems were far from where they needed to be in compliance with ACA requirements that Medicaid eligibility determination and enrollment be real-time, web-based, user-friendly, and seamless with the processes for enrolling in exchange-based coverage.

Implications of SHAP State Experiences with Medicaid Enrollment and Systems for Planning and Developing Systems for ACA

Recognize Need for IT Improvements

Though seemingly fundamental, officials described how critical it is for state stakeholders, especially policymakers, to understand why the state needs to invest in improving its enrollment and eligibility systems. Although the imperative for these investments has become that much greater with the passage of the ACA, when the study states began their IT modernization, the ACA was not yet part of the equation. For example, when Oregon began its effort nearly three years ago, it recognized a 30 percent gap between enrollee demand for eligibility and enrollment services and its caseworker capacity; this was before the ACA (which has

considerable implications for caseload) was passed. Oregon also recognized that their technology system was increasingly more expensive to maintain and, more broadly, had become a barrier to making policy changes quickly or introducing program innovations. New York officials offered that, among other things, process and system modernization would help them address the state's sizable population of individuals who are eligible for Medicaid but not enrolled.

In a similar vein, Kansas initiated its IT modernization efforts to address a lengthy application processing time, which had climbed to as long as 90 days due to recession-related volume increase. The state recognized that with health reform, application volume would at least triple and, moreover, that increase would happen in a compressed time period. Even with additional human resources, Kansas officials knew that their existing system could not handle the predicted caseload increase, and it became clear to them that technological changes were needed. Each of the study states echoed this sentiment that with national reform, their current eligibility and enrollment systems (including caseworkers) simply would not be able to handle the influx of applications expected under reform.



Subject Matter Experts Needed in All Phases of Modernization

Universally, study states stressed the importance of engaging individuals who knew the ins and outs of Medicaid eligibility and enrollment—the “subject-matter experts”—to guide the development of eligibility and enrollment systems including state eligibility and enrollment policy experts, county caseworkers, outreach workers, and the IT experts. While IT expertise is important, officials in each of the states cautioned not to rely solely on technology experts. As one respondent put it, “IT is complex but that is the least of it; figuring out what you want to do and where to focus is bigger still.”

Officials also noted that once subject matter experts are gathered they should be involved in *all* phases of modernization—they encouraged project coordinators to “get [the experts] in the room and keep them there.” Further, several state officials highlighted the importance of obtaining input from major stakeholders within the agency where the system will be housed, and sometimes from other agencies. This helped immensely in getting cooperation and buy-in, and, critically, in the continued development and ultimate governance of the new system and processes.

Once subject experts are convened, respondents noted that the next step involves setting out what the system should do—defining the so-called “business requirements.” Improving IT is meaningless without knowing the business requirements, according to officials. This critical phase involves mapping out each step in the eligibility determination process such as what information is needed from the applicant, what information can be obtained from other databases to establish or verify eligibility, the rules that must be applied to determine eligibility for one or more programs, the roles and responsibilities of different agencies in each step of the process, and what information may be shared with other public programs. One informant noted, “Modernization should *not* be about replacing systems but understanding what data are required.”

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For example, when Colorado began designing its online application, it convened some 20 state policy and eligibility experts and went screen by screen through Wisconsin’s ACCESS (which served as Colorado’s application prototype) and listed all the changes or “business requirements” needed. The state used a similar process when designing its

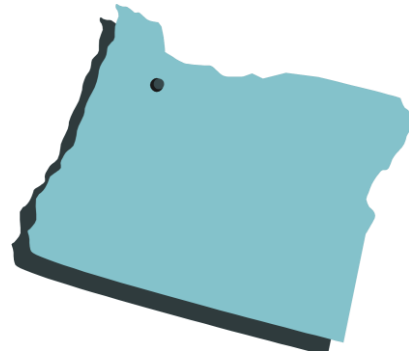
interfaces for electronic verification of data needed to determine eligibility.

When deriving business requirements, respondents strongly encouraged simplifying eligibility and enrollment processes as much as possible, which makes developing the “rules engine down the road a lot easier.” In addition, respondents cautioned to be realistic in the system that can be developed. The system will have limits; it cannot “be all things to all people.” Officials noted that acknowledging and understanding the limits of eligibility and enrollment systems is difficult but important given the tough fiscal environment most states are in, as well as the tight timeline imposed by the ACA to have systems meet the federal government’s “readiness” test by July 2013.

On a more practical level, SHAP state informants highlighted the importance of having a team of policy experts with dedicated time for the modernization effort as well as independent funding. Without this, state officials cautioned that efforts would likely fail, as staff inevitably will be pulled off the project to do their “real” work. States readily acknowledged that SHAP funding (as well as the more recently available ACA IT funding) afforded them the luxury to hire staff for their modernization that were full time or nearly full time on the effort, which helped immensely. Finally, officials cautioned not to underestimate the time it takes to organize business processes.

Look to Other States for Possible Models

In the early stages of design, officials from most states recommended looking to other states for IT ideas, solutions, and possible models. Minnesota officials, for example, noted that they tested online applications from other states, in part to educate themselves but also so they could describe to their IT vendor the “look and feel” of what the state wanted and did not want. For example, Utah’s E-find program served as an inspiration for Minnesota’s MN Verify, which interfaces electronically with multiple databases (e.g., wage and social security information) to obtain information that can be used to verify eligibility.



In a similar vein, New York officials offered that Louisiana’s program served as the model for its enrollment call center that began processing eligibility renewals by telephone in August 2011. Oregon expressed interest in pursuing an approach similar to the one Oklahoma takes when verifying income information. Specifically, Oklahoma allows self-attestation of income at the time of application and then electronically verifies the information using quarterly wage data when it becomes available a few months later. And, as noted above, Colorado used Wisconsin’s online application (ACCESS) as a prototype for the web-based application it developed.

Contracting with IT Vendors: Assess Needs First and Allow Ample Time

Each state highlighted the lengthy process to develop a request for proposals and procure an IT vendor. All advised to allow for a lot of lead time. New York’s procurement process for its enrollment call center took nearly two years. Kansas also described a two-year process to get an IT vendor for its new Medicaid eligibility and enrollment system. At the same time, one state official cautioned not to rush the vendor process because “you pay the price later.”

States had different perspectives on what stage in the development process was the best time to engage vendors. Some thought it was useful to get vendor input when drafting the request for proposals whereas others thought it was critical to have all the business processes worked out before bringing on the vendor.

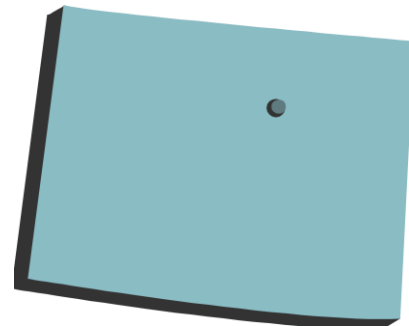
Taking somewhat of a middle ground, Oregon hosted a fair to explore vendors' different capabilities and systems before finalizing its request for IT vendor proposals.

One respondent observed by having both eligibility and enrollment experts working side by side with IT experts, “gave the agency tremendous lift in designing systems correctly.”

Regardless of the timing of vendor engagement, each of the study states agreed that subject matter experts needed to be part of the entire procurement process. While acknowledging that this may slow the effort, one respondent observed by having both eligibility and enrollment experts working side by side with IT experts, “gave the agency tremendous lift in designing systems correctly.”

In procuring an IT vendor, state officials noted a basic decision in the process is how much the state wants to rely on the vendor for the build process as well as management of the system once completed. Informants advised selecting vendors that complement and complete the skills and capabilities of state staff. At the same time, officials cautioned to be realistic about what can be done “in house.”

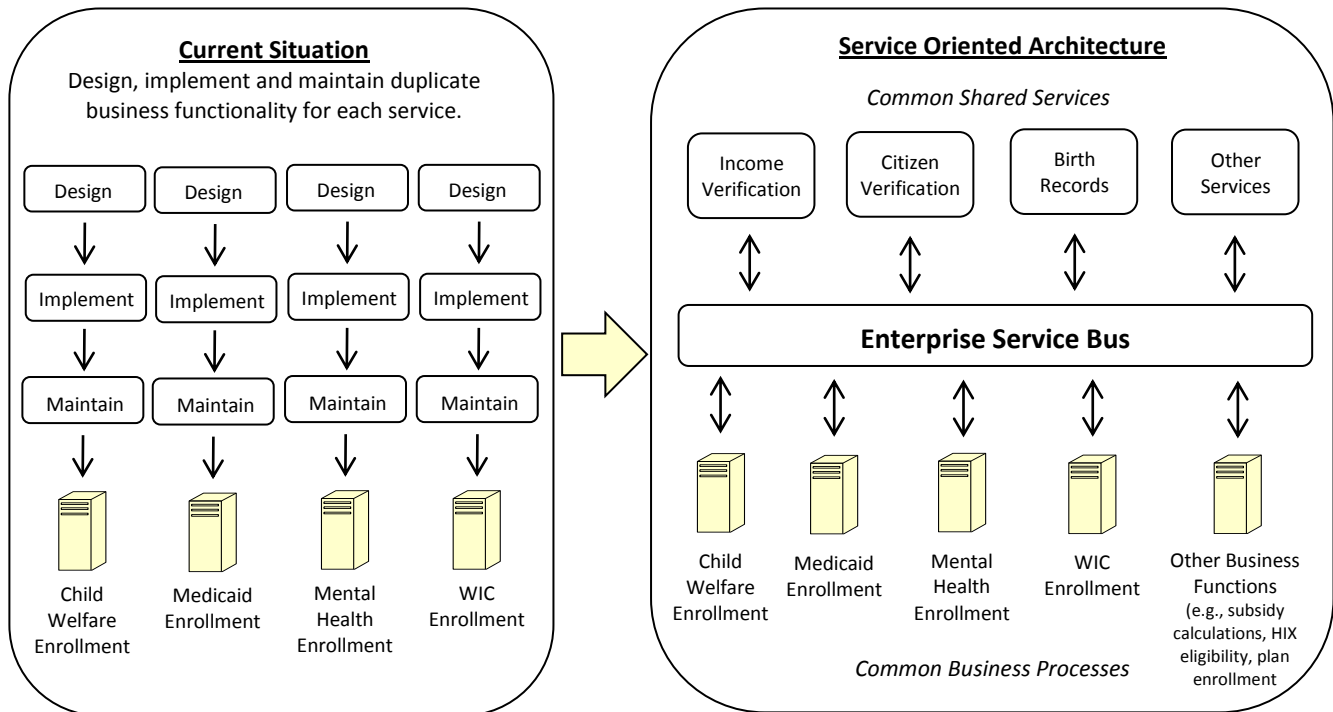
Study states varied considerably about what they were looking for in a vendor. At one end, Colorado relies heavily on its vendor for design and maintenance. Minnesota, by contrast, intends to do more of its systems work. As explained by state officials, Minnesota is one of 16 states that still operates its own Medicaid Management Information System and thus it has staff IT expertise that it has put to use in its eligibility and enrollment modernization efforts. Likewise, Oregon is relying on a vendor in its modernization effort but intends to use state staff to maintain the new systems. Indeed, as part of Oregon's arrangements with its vendor, selected state staff are being trained to maintain the system. Oregon argued that growing your “own experts” is critical to “really own and understand” the system. At the same time, Oregon officials acknowledge that future major system changes will likely require the state to once again engage a vendor.



Moving Away from Current Silo-Based System to a Service Oriented Architecture

A critical feature in each study state's modernization effort is the fundamental shift from the current “siloes” IT system—where duplicative pieces of data are collected, there is repeated functionality, inconsistent access and security, and a multitude of custom interfaces across silos and other data systems—to a system that uses a service-oriented architecture (SOA), which provides a platform upon which different “services” (for example a “verifying” service that checks citizenship status, employment or income) are built that can be scaled, reused, and shared for different purposes—say for determining eligibility for the HIX or Medicaid (See Figure 2.)

Figure 2. Service Oriented Architecture (SOA): An Illustration



Source: Draws from Oregon Department of Human Services, Office of Information Services. 2009. "Technology Plan: 2008-2015, Expanding Enterprise Capabilities, August 26.

Described alternatively as "a totally new mind set," "a sea change," and "going against every grain of every way the state built its systems before," SOA offers tremendous flexibility and economies of scale, according to state officials. While each state described its current IT system differently, common threads were clear: In the past, states would embark on an IT project by telling the vendor they wanted to do "X"—for example, adding cost-sharing for selected services for a specific Medicaid eligibility group. The vendor would take several months to build something unique to achieve "X"—a silo. The state would "flip the switch and close its eyes" and hope that that the new build actually performed "X." Over time, states developed many legacy systems—some more than 40 years old—with hundreds of interfaces that were built "on top of one another" and where each connection was a possible point of failure. Systems were not documented or standardized, data was housed in myriad places, and there was a lot of duplicative and inconsistent data. One respondent likened her state's IT system to the Winchester Mystery House, the California mansion known for its great size and its complete lack of a coherent master plan. Finally, states noted that their systems were expensive to maintain and any changes took a long time to implement.

In contrast, SOA involves a system of interchangeable business rules and services that can be re-configured (likened by one respondent as reconfiguring a Facebook page by uploading a picture) to serve other functions as well as other agencies. An example: For eligibility and enrollment purposes, services would include income verification, citizenship verification, vital records data matching, and the like. The services communicate with each other and data can be shared from one service to the next. In addition, services can work together to perform a coordinated "business process" such as determining Medicaid eligibility or health plan enrollment. Tying the services together is an Enterprise Service Bus or ESB.



One Minnesota official provided an example of how it would use SOA in its modernization effort. Under its old IT approach Minnesota would have built MN Apply—an intelligent-design online application that allows individuals to apply for several programs at one time—as a one-time project that would be unconnected to other state efforts or technological applications. With a SOA approach, however, Minnesota is designing service modules that will allow it to determine eligibility using the web-based application, but the modules can be used again for other purposes—eligibility for other programs among other things.

State officials were universal in their belief that SOA is the right vision for modernizing Medicaid eligibility and enrollment systems, but acknowledge that it takes more time to develop. Most believe that they will eventually get to the point where when a new business need arises (e.g., changing the poverty level for a program), the service components will already exist and the system will already have the functionality to meet the policy change.

A major challenge to transitioning to an SOA model is figuring out how to maintain existing systems at a minimal but necessary level while “turning on” the new system. States agreed that using an incremental approach and replacing components of the old system piece-by-piece is more careful and preferable than a “throwing a grenade in the whole system.” That said, states pointed out that the ACA calls for many different changes, from eligibility to delivery to payment system changes, which will be challenging for states to implement given the law’s aggressive schedule.

Extent of Integration between Medicaid and HIX Eligibility and Enrollment

Two basic design issues that states were debating at the time of our site visits were the extent to which Medicaid and HIX eligibility and enrollment were integrated (referred to “vertical integration”), and the extent to which health insurance enrollment and eligibility were integrated with eligibility and enrollment for social service programs such as SNAP and TANF (referred to as “horizontal integration”). States varied considerably on these issues.

At one end were Oregon and Minnesota who envisioned a single eligibility and enrollment system in which individuals could jointly apply for health programs (Medicaid and HIX) and social services programs. In other words, the system would be both horizontally and vertically integrated. At the other end, Colorado envisioned its eligibility and enrollment system for the HIX would be separate from but would interface with the systems used for Medicaid and social service programs. Kansas and New York fell somewhere between.

State officials offered different rationales. Those pursuing a vertically integrated approach maintain that with the passage of the ACA the country has made the decision that all Americans should have health insurance, and Medicaid is now just another type of insurance along a continuum of coverage, and thus it should be integrated with the HIX. At the same time, the argument was made that by linking enrollment and eligibility for the HIX with Medicaid, the HIX could suffer: If associated with Medicaid, the HIX runs the risk of being viewed by consumers as welfare, which could dampen HIX enrollment. Instead, for those with this view, the HIX enrollment and eligibility system could be separate but a “cousin” to Medicaid’s enrollment and eligibility (given that, at a minimum, the two systems must interact enough to satisfy the ACA’s “no wrong door” and seamlessness requirements).

Overlaying the vertical integration issue is how much horizontal integration there should be between health and social service programs. Some felt that Medicaid eligibility and enrollment should move away from eligibility and enrollment for social service programs. Such a separation would help to de-stigmatize Medicaid, a long-standing problem for the program, according to some officials.

Those pushing for horizontal integration of health and social programs counter there is much overlap between Medicaid and social services (in our study states, officials cited that as many as 80 percent of current Medicaid eligibles are also eligible for social service programs) and thus it makes sense to integrate the eligibility and enrollment systems--from an IT perspective and from a program enrollee's perspective. That said, officials recognized that advocating for horizontal integration introduces additional challenges in an already challenging implementation environment. Among the many issues officials identified:

Resistance from Other State Agencies to Fully Integrate

State agencies tend to work in silos, and interests and missions are not always aligned. For example, Medicaid may pursue simplified and streamlined enrollment and eligibility processes but other agencies may not want or be able to take that approach.

Similarly, there are competing priorities across state agencies. What is a top goal for Medicaid is not necessarily so for other programs. Changes to an integrated system require approval from all agencies (programs) involved, and this may be hard to obtain.

The most restrictive eligibility and enrollment rules generally prevail in an integrated system. For example, SNAP requires a face-to-face interview to determine eligibility and more frequent re-determination periods than Medicaid.

Systems of other agencies may not have the software upgrades to move forward with integration.

Given these and other challenges, coupled with the aggressive timeline that states are operating under to comply with the ACA requirements, states that were pursuing a more integrated eligibility and enrollment system noted that they would initially work on developing the Medicaid and HIX system components so that these would be ready by October 2013 (the start of the open enrollment period for the Exchange plans beginning in 2014). Social services programs would be added to the system in future phases.

State officials highlighted that with their move to SOA, adding social services on in the future will not be so onerous. Many of the services they are configuring now for Medicaid and HIX eligibility and enrollment can be scaled and re-used when social services are added. Further, with federal funds available from the ACA for HIX system development as well as the availability of enhanced federal Medicaid matching funds for the overhaul, upgrade, and maintenance of Medicaid systems,⁷ significant money is available to states for IT system investments. As many states highlighted, given their recent fiscal problems, it simply has not been feasible to obtain state funding to undertake IT modernization. With the influx of federal funds, the HIX and Medicaid can "buy the condo complex and several floors; other public programs can come in fill out remaining floors without having to buy the whole condo again."

⁷ States are eligible for an enhanced federal Medicaid matching rate of 90 percent for design and development of new Medicaid eligibility systems and a 75 percent matching rate for maintenance and operations. States must meet certain conditions, including seamless coordination with the exchanges, in order to qualify. The 90 percent matching rate is available for eligibility systems until December 31, 2015, and the 75 percent match is available beyond that date, assuming the conditions continue to be met. More information can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>

Need to Maintain Current Eligibility Workers

Without exception, states fully recognize the need to maintain current eligibility workers to provide in-person enrollment assistance and eligibility determination. Even with the most sophisticated IT system, state officials understand it is necessary to retain eligibility workers to enroll Medicaid “legacy” populations (i.e., those not newly eligible under national reform, such as elderly and disabled beneficiaries) and to handle complicated cases. According to one respondent, enrolling in Medicaid is a “human process with human needs,” and not all cases can be handled by automated systems. In addition, at the time of our site visits, state officials did not have a good handle on what share of prospective enrollees would access the system electronically, further suggesting the need to retain case worker capacity (though potentially at a reduced level) with the understanding that the roles and responsibilities of these workers would evolve in response to the ACA requirements.

As the new IT is phased in, existing caseworkers and new hires require training. As part of their SHAP grants, some of the study states—including Colorado, Minnesota, and New York—introduced system changes that directly affected caseworkers. Officials in these states emphasized that addressing changes at the caseworker level is critical. Given the volume of changes, states run the risk of overburdening caseworkers, who must learn to use the new system while maintaining their current caseload. Our study states suggested using a strong “change management process” (i.e., a structure for helping staff transition from current roles and functions to future roles and functions) in place, as well as engaging caseworkers and others who assist with Medicaid enrollment (e.g., Community-Based Organizations) early and often throughout the modernization process.

Conclusion

The SHAP grant has played a direct role in helping each of the five study states realize their own health reform goals, as well as putting them on the right track to meet the goals put forth by federal health reform. State officials described SHAP as “driving the process” of ACA implementation, and noted that their work under the grant served as a natural precursor or bridge to federal reform. Undoubtedly, the dedicated funding for eligibility and enrollment system improvements that SHAP provided gave these states a head start on complying with the ACA’s many requirements for system modernization.

Given this head start, these states’ experiences offer important insights for those states in earlier stages of ACA implementation that may be grappling with issues related to system design and business requirements, vendor selection, the desired level of vertical and horizontal integration, and the evolving roles of local eligibility caseworkers.

The improvements initiated under SHAP and continued as part of ACA implementation represent major systems change that will usher Medicaid eligibility and enrollment systems into the modern world and help make Medicaid more efficient and easier to use for both caseworkers and clients. While investments in IT are a major piece of this change, it is equally critical that system modernization also entail continued retooling of eligibility and enrollment processes and people, both workers and consumers.

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About SHADAC

The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by the Robert Wood Johnson Foundation to collect and analyze data to inform state health policy decisions relating to health insurance coverage and access to care. For information on how SHADAC can assist your state with small area estimation or other data issues relevant to state health policy, please contact us at shadac@umn.edu or call 612-624-4802.