shadac
State Health Access Data Assistance Center

State Health Access Program State Medicaid Eligibility System Survey:
Report on the Modernization of State Medicaid Eligibility Systems

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Executive Summary

In an effort to learn and share state plans for and progress made toward upgrading Medicaid eligibility systems in light of national health reform, the University of Minnesota's State Health Access Data Assistance Center (SHADAC) fielded a survey of State Medicaid Directors for their perspectives on the topic. The purpose of this study was to delve behind the user experience of Medicaid eligibility and enrollment to better understand the technical situations and upgrade issues the states are facing. The survey addressed a subset of issues of import to state and federal decision makers related to state Medicaid eligibility system enhancements. The survey results provide point-in-time answers from 30 study states on issues relating to preparations to address federal eligibility system reforms, use of vendors, eligibility support for individuals who qualify for other non-health related programs, including social services, food and housing assistance, and integration with Exchanges.

Current Systems and Pre-ACA Modernization

A baseline assessment confirmed that many states are relying on older, legacy Medicaid eligibility systems with limited technical and functional capacity to support streamlined processes called for under national health reform. Many of the oldest systems have been highly modified and have limited capacity for further updates or patches, which are time consuming and costly to implement in mainframe environments. A few study states operate more modern client/server systems, and just five states report building systems on a more flexible, Internet-based platform.

The majority of study states operate integrated eligibility systems, meaning that systems serve more than just individuals enrolled in Medicaid programs. Systems in most study states support Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF) programs, and some study states determine and/or track eligibility for other federal and state programs. The majority of study states reported that their current eligibility systems are managed outside of the state Medicaid agency, or the state Medicaid agencies share responsibility for managing systems and overseeing budgets with other government agencies.

Most study states report that their eligibility determination processes are partially or mostly automated and decentralized. Many study states report manual workarounds because rules changes can take months to code and implement, and that this type of investment is not practical for already outdated systems. In addition, system automation is not designed for all Medicaid populations. Several study states rely on more manual processes to determine non-financial eligibility for populations such as the aged, blind and disabled. Less than half of study states reported some capacity to verify applicant information electronically through system linkages to other state or federal data sources. Just one study state is able to make eligibility determinations in "real-time". Study states almost universally reported the need for more agile eligibility systems that can respond accurately to underlying program changes and requirements with minimal programmer input and worker training.

Preparing Medicaid Eligibility Systems for 2014 and Beyond

All study states responded that they are planning to or are in the process of making changes to their existing Medicaid eligibility systems to achieve guidelines set forth by the Affordable Care Act (ACA) and/or the Centers for Medicare and Medicaid Services (CMS), as well as to realize state plans for system improvement. Two-thirds of study states plan to replace all or part of their existing systems that support Medicaid eligibility determination. The study states are at varying stages of planning and implementation, and many of them must phase in their upgrades rather than see them all realized in January of 2014. Some study states are taking a "build it for Medicaid first" or "built it for Medicaid and other public programs first," and others are taking a "build it for the Exchange first" approach. Several study states expect to fully integrate eligibility functionality for Medicaid and Exchange programs (if applicable) and other public programs in their replacement systems at a later point. At the time of data collection, we approximate that ten study states were in the planning phase (information gathering and requirements identification) and seven states were actively procuring vendor services to modernize systems or to develop new Exchange systems. Nine study states had begun system design and implementation.

Some study states mentioned that vendors, through request for information (RFI) processes, have helped them think through the options for replacement systems. These options commonly include systems developed in another state that can be purchased and customized, a commercial off the shelf system with lower up-front development costs but long-term licensing and customization costs, and a custom system, which may take longer to design and implement.

A primary goal of system changes for many study states is to support real-time eligibility determination for the modified adjusted gross income (MAGI) Medicaid population through an automated, Internet-enabled flexible, interface, consistent with ACA demands. Many study states also envision a customer portal to put more information into the hands of the applicants. Most study states intend to capitalize on the new system architecture and functionality for non-MAGI Medicaid categories and other human service programs.

Most study states are gearing their plans according to ACA requirements and CMS enhanced funding deadlines to modernize the information systems that support Medicaid eligibility determination. ACA calls for states to be ready to enroll MAGI Medicaid populations, among other Exchange populations, by October 2013 and be fully operational by January 2014. CMS enhanced funding expires in December of 2015. Eight states report that they hope to achieve their goals for system modernization by January 2014. Five states report plans to accommodate all of the Medicaid eligibility requirements by the ACA deadline, including MAGI Medicaid, CHIP, and the non-MAGI populations, phasing in the integration of other human services programs later. Ten study states report phasing implementation, with plans to accommodate only the MAGI Medicaid population under their system changes by January 2014 or earlier. Six study states were unable to forecast their timeline for modernized systems to go live at the time of the survey discussions.

There is recognition among many study states that eligibility determination for non-MAGI Medicaid populations will not be "real time" nor fully automated, and will remain unchanged in the short run as legacy systems will continue to support this population. Several study states cited the importance and

efficiency of precise screening and tracking of non-MAGI populations due to the high likelihood of crossover eligibility with Exchange populations.

Study states are either participating in or actively monitoring state discussions regarding pursuit of state Exchanges while modernizing their eligibility systems. Seventeen study states reported that their state was planning to create a state Exchange. Eleven of the study states were unsure at the time of the survey discussions, and two study states reported plans to use the Federal Exchange.

ACA requires coordination between state Medicaid agencies and Exchanges. Among study states pursuing a state Exchange, the degree of collaboration between Medicaid eligibility system modernization and Exchange planning efforts varies. Some respondents described the efforts as well-integrated; some view the two efforts as separate projects working in tandem, and maintain regular communication between project teams with plans to build data sharing functionality into the architecture of both systems. About half of study states expect that their current or transformed Medicaid eligibility system will also support subsidy eligibility determination for the proposed Exchange.

Medicaid eligibility system modernization projects represent huge undertakings and efforts to upgrade outdated eligibility systems predate ACA. Historical barriers to modernization included lack of funding, lack of awareness of the investment needed for system changes, lack of executive-level commitment, interest in upgrading MMIS before eligibility systems, and/or lack of staff expertise. Other challenges noted by study states with respect to modernizing integrated eligibility systems include the need to involve multiple agencies in the decision making process. Investments in state-of-the-art, modular information technology can be significant and underscore the importance of convincing leaders of the business case for multi-year and, in many cases, multi-million dollar system change efforts. System upgrade timing is an issue as states are attempting to make decade's worth of upgrades in less than two years. With final ACA Medicaid and Exchange eligibility rules recently released, all states will benefit from continued opportunities to learn, discuss, and share with the ultimate goal of successful eligibility system modernization efforts.

I. Introduction and Background

The call to simplify state eligibility and enrollment processes for affordable health insurance programs in the Affordable Care Act (ACA) of March 2010 presents great challenges for state government agencies, but also presents great opportunities. State Medicaid agencies, in particular, are busy with the tasks and imminent decisions that must be made related to revising policies and deploying systems to meet ACA Medicaid eligibility and enrollment requirements. Considerations include, but are not limited to: support for faster, more accurate, and streamlined eligibility determination, verification and redetermination for new and existing Medicaid populations; enhancing customer service; minimizing coverage gaps; leveraging available data; integrating eligibility and enrollment functions with other public programs; and supporting evaluation and reporting.

Additionally, Medicaid eligibility system modernization efforts are taking place at the same time as states are preparing to meet the Affordable Insurance Exchange (Exchange) provision in ACA. Exchanges (to be implemented in January 2014) are government-regulated insurance marketplaces run by states or the federal government designed to increase access to and facilitate purchase of affordable health insurance for individuals and small businesses. One major component of Exchange functionality is determining consumer eligibility for health insurance subsidies. ACA requires coordination of eligibility determination for Medicaid and other Exchange populations, such as individuals eligible for advanced payment of premium tax credits.

In response to federal requirements and in order to enhance state programming to better serve customers, state Medicaid agencies are in the midst of upgrading their Medicaid eligibility systems into compliant, streamlined, technologically-updated information systems. The opportunity for enhanced federal funding through December 2015 (known as the 90/10 rule) from the Centers for Medicare and Medicaid Services (CMS) to modernize Medicaid eligibility systems has motivated state efforts to embark on massive information technology projects to update what are, in many cases, decades-old legacy systems that support eligibility determination for Medicaid and other public programs. Federal Early Innovator grants also jump-started the development of information technology needed for Exchanges for eight states.[1] The benefits of Medicaid eligibility system updates include, but are not limited to:

- flexible, scalable, intuitive, integrated information systems;
- customer-centered solutions;
- more accurate determinations;
- faster application processing that is online and "real-time" ;
- seamless program transitions;
- reduced worker training and manual inputs;
- improved worker retention;
- increased availability of data in electronic form; and
- improved data quality and reporting.

[1] "Early Innovator" grants were awarded by HHS to help states design and implement the technical infrastructure to operate exchanges. In February 2011, seven grants were announced, including one to a five-state consortium. Three states returned federal grants since initial awards.

Timeframes required for implementing major system changes are tight, and coincide with other state efforts to upgrade information technology and automate information flow [e.g., Medicaid Management Information System (MMIS) procurements and conversion to the new International Classification of Diseases standards (ICD-10)]. Furthermore, states continue to face staffing and budget constraints. In addition, federal guidance had been slow regarding final ACA Medicaid and Exchange eligibility rules (at the time of fielding), including specific provisions for the federal Exchange option and the federal data hub[2], both of which necessarily factor into state decision making.[3] Many state agencies are operating in uncertain political environments, including constitutional challenges to the ACA altogether. For example, 26 states have filed law suits challenging the ACA.[4]

In an effort to learn and share state plans for and progress made toward upgrading states' Medicaid eligibility systems in light of national health reform, the University of Minnesota's State Health Access Data Assistance Center (SHADAC) fielded a survey of State Medicaid Directors for their perspectives on the topic.[5] This work supplements SHADAC's role as evaluation and data technical assistance contractor for the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), State Health Access Program (SHAP).[6]

This report describes the survey framing questions and methods, and presents findings about current Medicaid eligibility systems in study states and planned systems changes to support individual eligibility determination processes called for under national health reform. This report further offers a discussion of key considerations for states as they adapt their Medicaid eligibility systems to be consistent with ACA requirements and meet the unique needs of their programs.

[2] The "hub" is a data service operated by CMS that will provide access to multiple data bases of federal and state agencies, allowing states to cross-check the applicant across all data bases at one time.

[3] Only proposed rules were available at the time of this study. Exchange eligibility final and interim rules and the parallel Medicaid rules were posted on March 12, 2012 and March 16, 2012, respectively.

[4] States involved in this law suit are listed at the web page, "The States' Lawsuit Challenging the Constitutionality of the Health Care Reform Law", available at http://www.healthcarelawsuit.us/, accessed March 9, 2012.

[5] SHADAC contracted with C A Worrall Consulting, LLC, to design and administer the data collection instrument and report findings. In an earlier SHAP task, SHADAC contracted with the Urban Institute to conduct case studies in five SHAP states (Minnesota, New York, Kansas, Colorado and Oregon) that used grant funds to support eligibility and enrollment system enhancements.

[6] For more information about the SHAP program, follow this link http://www.hrsa.gov/statehealthaccess/.

II. Study Purpose

This study aimed to delve behind the user experience of Medicaid eligibility and enrollment to better understand the technical situations and upgrade issues the states are facing. The survey addressed a subset of issues of import to state and federal decision makers related to state Medicaid eligibility system enhancements. The survey results provide point-in-time answers to the following questions from the viewpoint of state Medicaid directors or their designees:

- To address required federal eligibility system reforms, are state Medicaid agencies planning to create new Medicaid eligibility systems or modify (components of) existing systems?
- What have been state Medicaid agencies' experiences in the last several years with the use of vendors to help the design, implementation and/or operation of changes to Medicaid eligibility systems?
- Are state Medicaid agencies addressing eligibility determination of Medicaid recipients whose eligibility is not determined by the new Modified Adjusted Gross Income (MAGI) criteria in planned system changes? If so, how? If not, why not?
- Will ACA-compliant state Medicaid systems (continue to) support eligibility of individuals who qualify for other non-health related programs, including social services, food and housing assistance?
- Will Medicaid eligibility systems serve as the foundation for eligibility and verification in the planned (or existing) Exchange?

III. Methods

SHADAC invited Medicaid Directors or their designees in all 50 states and the District of Columbia to complete the SHAP State Medicaid Eligibility System Survey. Telephone calls were made to the offices of each Medicaid Director to introduce the survey effort. Follow up e-mails from SHADAC's Director, Lynn Blewett, were sent to either Medicaid Directors or individuals recommended by the Medicaid Director's office to complete the survey; these e-mail invitations included a copy of the survey form.

The survey consisted of two parts: in Part 1, participating states were asked to verify prepopulated information and complete questions about the characteristics of their current computer systems and processes used to support individual Medicaid eligibility determination. Study states were also asked to provide their current understanding of Affordable Insurance Exchange planning in the state. Responses were entered into an electronic version of the survey form and e-mailed to SHADAC. Part 2 of the survey included a few questions about planned system modifications; these questions were administered during a brief telephone discussion between SHADAC's consultant and each of the participating states. The survey instrument is presented in Appendix B and closed-ended question response counts are in Appendix C.

SHADAC piloted the survey with a subset of SHAP grantees (Kansas, New York, Oregon and Minnesota) in mid-November 2011. The revised, final survey form was sent to the remaining SHAP states, followed by the rest of the states over a two month period (December 2011 and January 2012). Survey administration for participating states was completed by mid-February 2012.

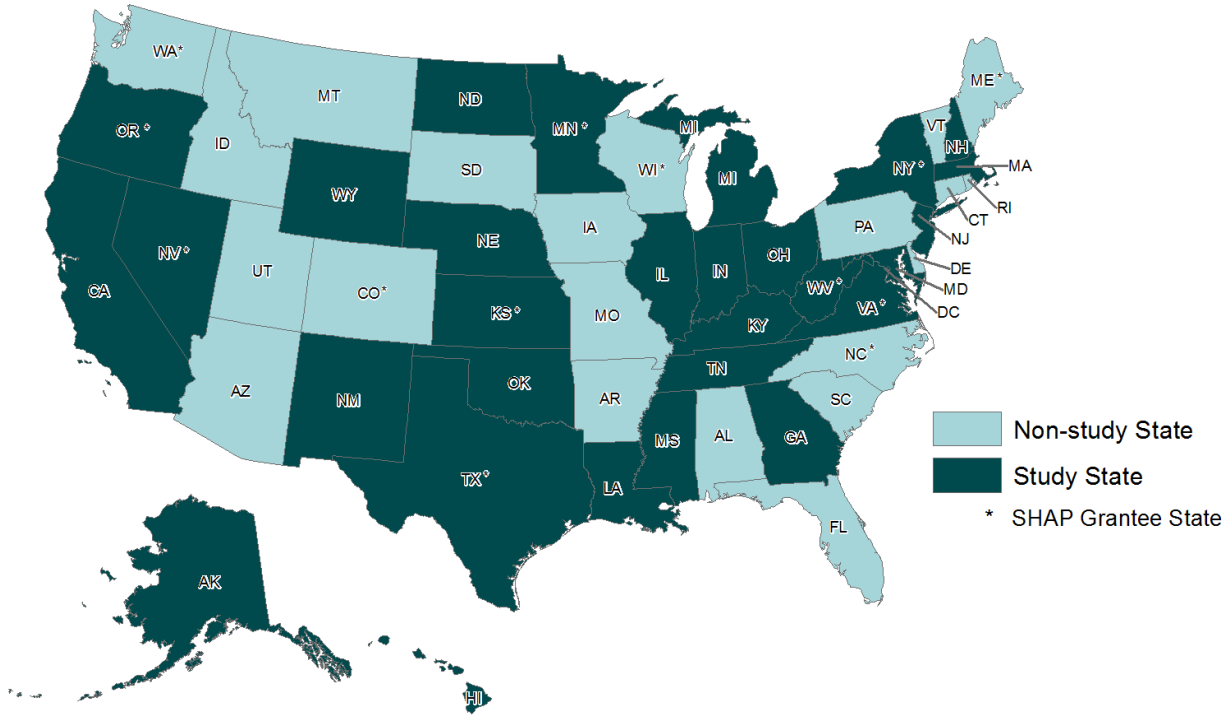
The survey scope was limited to state efforts related to systems that support eligibility determination. The survey did not include specific questions about state plans for revising eligibility and enrollment policies but these efforts precede decisions about system design. Discussions about system transformations remained at a high level and did not probe for technical detail.

A. Respondent Information

Thirty states, including the District of Columbia, participated in this study, with 8 of the 13 SHAP grantee states participating (see Exhibit 1). This represents 68% of the country's population. Survey participation was voluntary; SHADAC followed the lead of state agency representatives as to whether they were interested and able to complete the form. In three cases, states chose to return the form but not participate in the follow up telephone call. In one case, the study state completed only Part 1 of the survey.

Survey completion by study states involved from one to seven individuals. Several states involved representatives from outside of the Medicaid office, including state human services and information technology personnel, as well as staff or contractors contributing to health reform implementation.

Exhibit 1: States Participating in the SHADAC SHAP Medicaid Eligibility System Survey



Note: A list of study states is presented in Appendix A. SHAP grantee states include CO, KS, ME, MN, NC, NV, NY, OR, TX, VA, WA, WI, and WV.

B. Survey Limitations

Because the sample is limited to 30 states the findings are not projectable to all states. Exhibit 2 compares study states and non-study states across several characteristics that may impact interpretation of study findings. Study states are slightly overrepresented in the southern region and are more likely to have a larger proportion of their population enrolled in Medicaid.

Exhibit 2: Profile of Study States vs. Non-Study States

	Study States		Other States		Total	
	Count	Percent	Count	Percent	Count	Percent
Total responding states	**30**		**21**		**51**	
Region						
Midwest	8	27%	4	19%	12	24%
Northeast	4	13%	5	24%	9	18%
South	11	37%	6	29%	17	33%
West	7	23%	6	29%	13	25%
Medicaid enrollment as a percent of population[7]						
<15%	10	33%	4	19%	14	27%
15% to 19%	8	27%	12	57%	20	39%
20% or more	12	40%	5	24%	17	33%
Average		18%		18%		18%
States that have filed a suit challenging ACA	13	43%	13	62%	26	51%
State action to form an Exchange[8]						
Enacted Establishment Legislation	8	27%	5	24%	13	25%
2012 Legislation pending	12	40%	9	43%	21	41%
Legislative action not taken	10	33%	7	33%	17	33%
Early Innovator states[9]						
Early Innovator Grant	4	13%	4	19%	8	16%
Not an Early Innovator	26	87%	17	81%	43	84%
Establishment grantee[10]	17	57%	12	57%	29	57%

Note: Significance testing was not conducted. Percents may not add to 100% due to rounding.

[7] Kaiser Family Foundation State Health Facts. 2011. "Total Medicaid Enrollment, FY2008" web page, http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4 , accessed October 18, 2011; 2010 American Community Survey.

[8] National Conference of State Legislatures. 2012. "State Actions to Implement Health Insurance Exchanges" web page, March 2012 Update, http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx, accessed March 9, 2012.

[9] Kaiser Family Foundation State Health Facts. 2012. "Total Health Insurance Exchange Grants, 2011" web page, http://statehealthfacts.kff.org/comparetable.jsp?ind=964&cat=17, accessed February 20, 2012.

[10] Sixteen additional Exchange establishment grants were issued by HHS after study data collection was completed: AR, CO, KY, MA, MN, NV, NJ, NY, PA, and TN (http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/02/hhs-announcement-exchanges.pdf) accessed February 22, 2012.; and IL, NV, OR, SD, TN, WA (http://www.hhs.gov/news/press/2012pres/05/20120516a.html) accessed May 18, 2012.

IV. ACA and CMS Guidance

Medicaid eligibility simplification is a requirement of the ACA. Notably, study states cited ACA proposed rules and/or the CMS "90/10" rule for enhanced funding as the basis for their plans to modernize the information systems that support Medicaid eligibility determination (see Exhibit 3). An important eligibility change for the ACA is income determination based on MAGI. MAGI populations will encompass most Medicaid applicants (the expansion population of childless adults and the three eligibility groups for children and families) whose eligibility determination is based on a simplified income standard that is consistent with IRS reporting. Medicaid applicants that require the traditional income and asset test review for determination are referred to as non-MAGI. The latter include populations such as the Aged, Blind, and Disabled (ABD) population, Supplemental Security Income eligibles, dual-eligibles, individuals receiving long term care services, and the medically needy.

To comply with the 90/10 rule, many study states are submitting to CMS Advanced Planning Documents (APD), which outline how state Medicaid eligibility system modernization efforts align with CMS' seven standards and conditions for Medicaid information technology.[11] Once approved, states are eligible for 90 percent federal financial participation (FFP) for the system design, development, implementation and/or enhancements and 75 percent federal funding for ongoing maintenance and operations. The temporary waiver from cost-allocation requirements issued by HHS in August 2011 appears to be enabling state plans to support integrated eligibility systems. This means that development costs incurred for the Medicaid, the Children's Health Insurance Program (CHIP) or the Exchange portion of state systems do not need to be cost-allocated if other programs also benefit.

Most state Medicaid eligibility systems, regardless of age, are not designed to easily incorporate the new MAGI Medicaid population, nor can they be readily modified to address other ACA requirements and CMS guidance, such as "real time" determinations (i.e., made right away) and "reasonably compatible" verifications (i.e., consistent applicant information) or modularity standards (i.e., flexible design). Ensuring that this occurs will require changes to current policies as well as significant technological investments. In addition, study states are deliberating over whether, when, and how to address non-MAGI and other non-Medicaid or non-Exchange populations in eligibility system upgrades. Recent advancements in information technology are making it increasingly possible for states to employ the tools and expertise needed to create flexible, scalable, and effective systems.[12]

[11] According to a 2012 national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 18 and 11 states, respectively, have received approval for or submitted plans to upgrade their eligibility systems with enhanced CMS funding (Heberlein, M., et al. 2012. "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-sharing Policies in Medicaid and CHIP, 2011-2012." Washington DC: Kaiser Commission on Medicaid and the Uninsured). This number has increased as a few study states reported recent approvals from CMS and new submissions.

[12] Enroll America. 2012. "Verifying Eligibility in the Digital Age" webinar, held February 15, 2012. Archive available at http://www.enrollamerica.org/best-practices-institute/webinar-archives/verifying-eligibility-in-the-digital-age.

Exhibit 3: ACA Rules and CMS Guidance Pertaining to Medicaid Eligibility System Improvements

ACA's August 2011 Notice of Proposed Rulemaking (NPRM) outlines streamlined Medicaid eligibility processes states must implement by **January 2014**:

- Use simplified eligibility rules for three eligibility groups for children and families and a childless adult group eligible up to 138 percent of the federal poverty level under a new Modified Adjusted Gross Income (MAGI) standard.
- Offer a single streamlined application for all insurance affordability programs, e.g., Medicaid MAGI, CHIP, advance payment of premium tax credits and cost-sharing reductions through the Exchange and any state-established Basic Health Program that can be submitted online, over the telephone, in person or by mail. (Proposed regulations permit electronic, telephonic and facsimile signatures.)
- Verify customer data electronically at enrollment and renewal using a "reasonably compatible" standard and secure data exchanges. States can accept self-attestation with the exception of citizenship and immigration status; paper documentation is a last resort. A data services or "federal data hub" will be established for electronic verification.
- Provide assisted and easy process for customers, including making information available electronically, establishing a website, linking to an Exchange web-site. (Exchanges will not be required to undertake other than Medicaid eligibility determinations on the basis of MAGI.)
- Participate in a coordinated, "no wrong door," eligibility and enrollment system that screens for all programs and facilitates enrollment in and seamless transfers to and from the appropriate programs.
- Employ advanced technology to support real time (to the greatest extent possible) and accurate eligibility determination and efficient electronic data exchange.

Building on the work of the Medicaid Information Technology Architecture (MITA), in April 2011, CMS issued new standards and conditions that must be met by states in order for Medicaid technology investments to be eligible for enhanced match funding through **December 31, 2015**:

- Modularity standards – requires use of modular, flexible approach to systems development [employing service-oriented architecture (SOA) principles].
- MITA condition - align to and advance in MITA maturity for business, architecture and data.
- Business results conditions - ensure accurate and timely processing of data and effective communications.
- Industry standards conditions - adhere to standards such as security, privacy and accessibility standards.
- Leverage condition-promote sharing and reuse of Medicaid information technology applications.
- Reporting condition –produce data to support evaluation, reporting, improvement, transparency, accountability.
- Interoperability condition – maintain seamless coordination and integration with Exchange (whether state or federally run) as well as interoperability with other entities housing health and human services data.

Sources: (1) Centers for Medicare and Medicaid Services. 2011. "Enhanced Funding Requirements: Seven Conditions and Standards." Medicaid IT Supplement (MITS-11-01-v1.0). Washington DC: U.S. Department of Health and Human Services.
(2) State Health Reform Assistance Network. 2011. "Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011." Princeton, NJ: Robert Wood Johnson Foundation, available at http://www.rwjf.org/files/research/72795manattregulations20110902.pdf;
(3) Rosenbaum, S. 2011. "Update: Medicaid Program Eligibility Changes under the Affordable Care Act." Health Reform GPS blog posting, August 31, 2011, available at http://www.healthreformgps.org/resources/update-medicaid-program-eligibility-changes-under-the-affordable-care-act/, accessed October 18, 2011.

V. Findings

The results of the SHADAC SHAP State Medicaid Eligibility System Survey are presented below in two sections. The first section summarizes existing information systems used to support individual eligibility determination for Medicaid (including system age, platform, programs supported, and agencies involved), and further describes the extent to which these systems have been updated in the last decade to improve the eligibility determination and verification processes. The second section reviews actions taken by the 30 study states (most often from the perspective of the state Medicaid agencies) to modernize their eligibility systems specifically to address health reform and related requirements.

A. Current Systems and Pre-ACA Modernization

To establish a basis for discussion, we reviewed each study state's current, primary Medicaid eligibility system. Study states typically have a single system used across the state, except for a couple of states that have separate systems for populous metropolitan areas. See Appendix D for a list of system names by state.

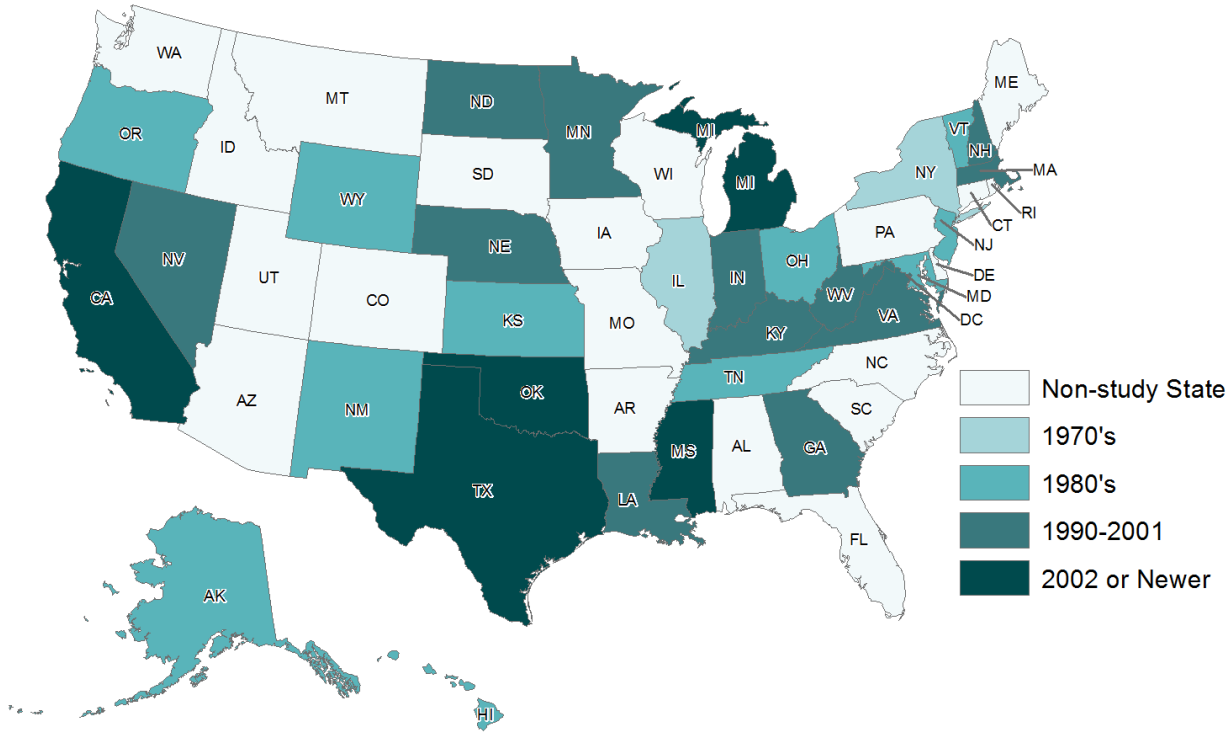
New Demands, Old Systems

This study confirmed that many states are relying on older, legacy systems with limited technical and functional capacity to support streamlined Medicaid eligibility processes called for under national health reform. Twelve study states report that their systems that support individual eligibility determination for Medicaid were first implemented between 20 and 40 years ago, and another 13 study states are relying on systems at least 10 to 20 years old. Only 5 study states have systems that were installed in the last decade (see Exhibit 4).

Many of the oldest systems are already operating at capacity in terms of functionality and size. Most study states' systems were built on a mainframe platform and many study states reference use of "black screen, green text" terminals with command line interfaces. Many of these systems have been highly modified and have limited capacity for further updates or patches, which are time consuming and costly to implement in mainframe environments. A few study states operate more modern client/server systems. Only the 5 states that replaced systems in the last 10 years (California, Michigan, Mississippi, Oklahoma, and Texas) report building systems on a more flexible, Internet-based platform.

The majority of study states operate integrated eligibility systems, meaning that systems serve individuals enrolled in Medicaid and other public programs. The burden on Medicaid eligibility systems is expected to increase across all study states when new Medicaid populations become eligible to enroll and more updated methods of eligibility determination are employed for previously eligible populations. A table showing estimated enrollment data for the study states is in Appendix F.

Exhibit 4: System Age by Study State



Systems Support More Than Medicaid

In most of the study states, Medicaid is neither the only public benefit program that state eligibility systems support, nor the only agency with system responsibility. Systems in 23 out of the 30 study states support Medicaid, the U.S. Department of Agriculture's Supplemental Nutrition Assistance Program (SNAP), and HHS Administration for Children and Families' Temporary Assistance to Needy Families (TANF) programs. Several study states report using current systems to also determine and/or track eligibility for other federal and state programs, with Child Care and Low Income Heating and Energy Assistance Program reported most often. On average, current eligibility systems support 4 other public benefit programs in addition to Medicaid and/or CHIP. Study states range from supporting 2 to 30 programs in their current eligibility systems, including the associated business rules and documentation requirements. Six study states described their systems as supporting Medicaid, CHIP and/or other health insurance programs. Eight study states use a separate system to determine eligibility for the Children's Health Insurance Program (CHIP) from the system that supports the rest of the Medicaid population.

The majority of study states report that their current eligibility systems are managed outside of the state Medicaid agency, either by an umbrella agency, an information technology office, or a sister agency that oversees other human service programs (e.g., welfare), or the state Medicaid agencies share responsibility for managing systems and overseeing budgets with other government agencies. Only six

study states report that the state Medicaid agency is solely responsible for managing the current Medicaid eligibility system and overseeing its budget.

Degree of Automated Functionality in Eligibility Systems

Most study states report that their eligibility determination processes are partially or mostly automated and decentralized. While eligibility systems consist of other applications – e.g., case management, service authorization, benefit payments, or MMIS transactions – SHADAC only asked states to identify whether their current systems could determine and redetermine eligibility and/or verify applicant information electronically. Twenty-two study states report electronic applications for determination and verification in their current systems; however, responses were highly qualified. Of the 25 study states that have not replaced their systems in recent years, 17 report that systems include rules to make initial eligibility determinations electronically, and 14 states do so for redeterminations. However, respondents noted that manual worker input is often required to enter application data at the front end, and to confirm or correct determinations at the back end. Many study states report manual workarounds because rules changes can take months to code and implement, and that this type of investment is not practical for already outdated systems. One respondent stated, "Major changes to financial rules in an integrated eligibility system, for example, cannot be made for one program without significant work to preserve proper determinations for other public benefit programs. In some instances it is not feasible to make necessary changes to the system and manual workaround by workers are necessary." In addition, system automation is not designed for all Medicaid populations. Several study states rely on more manual processes to determine non-financial eligibility for populations such as the ABD population.

Twelve study states reported some capacity to verify applicant information electronically – e.g., income, employment, and citizenship – through system linkages to other state or federal data sources. A subset of study states referred to verification capacity as semi-automated, meaning eligibility workers are alerted to and can view secondary data in separate screens but these data cannot be transferred electronically into the applicant's record in the eligibility system ("look and alert" as opposed to "grab and upload" functionality). Just one study state is able to make eligibility determinations in "real-time".[13]

Pre-ACA System Enhancements

State investments in system upgrades in the last ten years have contributed to some of the automation noted above. Twenty study states reported modernizing their eligibility systems in the last 10 years beyond routine maintenance updates. Modernization refers to system replacement (5 study states), and/or major modifications to the base system (5 study states), and/or the implementation of electronic tools (12 study states) that interface with the base system to facilitate Medicaid eligibility determination (see Exhibit 5). Some reasons cited for choosing to develop interface tools rather than making modifications to base systems include not having sole authority over the eligibility system and lack of resources (skills, time, and money) to further patch old systems.

[13] Detailed information by state on technological improvements to support application, enrollment and renewal procedures is available in Heberlein, M., et al. 2012. "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-sharing Policies in Medicaid and CHIP, 2011-2012". Washington DC: Kaiser Commission on Medicaid and the Uninsured.

Exhibit 5: System Age by Changes in the Last Year

System Age	Replace	Major Modification	Interface Change	None
1970's	--	--	2	--
1980's	--	--	3	7
1990-2001	--	4	6	3
2002 or newer	5	1	1	--
Total	**5**	**5**	**12**	**10**

Note: Responses are not mutually exclusive; two study states reported both system replacements and enhancements.

In general terms, a system replacement refers to states developing new systems that support revised eligibility policies and either retiring old systems or using them primarily as data repositories. As mentioned above, five study states made significant investments in the last ten years to roll out Internet-based systems, with rules engines to automate eligibility determination and redetermination, such that rules are consistently applied across applicants and can be revised for one program without requiring changes to other programs. Three of these study states support more than Medicaid programs in their systems; two study states chose not to integrate the eligibility determination for the ABD Medicaid population into updated systems. Two study states report enhanced capacity to verify applicant data electronically; however, additional upgrades are desired. Two of the five study states with systems built in the last decade support seamless transfer of information from online applications or other self-service functionality to the base system.

Similar functionality was added through base system modifications or via interface tools; however, interface tools are stand alone and often do not communicate with base eligibility systems. Examples of modifications to base systems include:

- upgrading hardware and software while maintaining a mainframe foundation;
- substituting modern language software for old programming languages (e.g., COBOL);
- increasing capacity to determine and redetermine eligibility through electronic applications and screening;
- electronic document imaging and filing as well as voice applications and electronic signatures;
- introducing or enhancing client and provider portals; and
- adding data warehouse and analytic capabilities.

Examples of interface tools include:

- customer portals (sometimes health-only) to begin and/or facilitate application or automated renewal processes or to check benefit offerings;
- tools to complete applications online (manual data entry is usually required to input data collected from online enrollment tools into eligibility systems for automated decisions);
- provider portals;
- electronic verification tools; and
- tools to manage staff workflow or to streamline the processing of paper documents.

Half of the Study States Used Vendors to Implement Pre-ACA Modernization

Approximately half (16) of the study states that implemented eligibility system changes over the last decade did so with the help of contract vendors. The prevalence among study states of vendor use to modernize or maintain any Medicaid system over the same period was much higher. Twenty-four study states reported awareness of vendor use in the last decade for modernizing or maintaining current Medicaid eligibility or other Medicaid systems; the majority of their vendor use in this time period was directed to MMIS system upgrades. A few study states expressed concern that the vendor pool and products for eligibility system modernization are more limited. See Appendix E for a list of vendors used by study states.

It is expected that most states will be using vendors in some capacity to meet ACA requirements. Twenty-two study states discussed plans to use vendors in some capacity, either to upgrade eligibility systems and/or to develop new Exchange systems. Informed by both positive and problematic experiences with vendors in the past, Exhibit 6 provides highlights from discussions with study states about how they are preparing for procurements, as well as how they are utilizing vendors for current eligibility system modernization efforts and related Exchange system endeavors.

A subset of respondents provided examples of how they have benefited from vendor relationships. Some study states complimented their vendor's (written and oral) responses to recent RFIs, which helped them make informed decisions regarding which system options to pursue and what technical requirements to include in their system modernization request for proposals (RFPs). A few study states also commented on the value of procuring an outside, unbiased, expert assessment of the extent to which current information systems can support health reform requirements, which they are using in support of their cases for system change.

Study States Hope for Extensive System Improvement

When asked about desired eligibility system functionality to better meet state Medicaid agency policy and program needs, study states almost universally reported the need for more agile eligibility systems that can respond accurately to underlying program changes and requirements with minimal programmer input and worker training. Medicaid eligibility system "wish lists" provided by study states are in Appendix G. As expected, there is alignment between federal rules and study state wishes.

Exhibit 6: Study State Vendor Utilization

Several study states shared insights into and suggestions for working with vendors on large information system design and implementation efforts:

Seek balance between specific system requirements and open-ended requirements in Request for Proposals (RFPs) to ensure vendor accountability as well as innovation and flexibility.
Several study states describe the importance of taking time to specify mandatory and desired system (business) requirements in RFPs, although this is difficult in some states with extremely long procurement processes. Proposals often become the basis for vendor contracts; therefore, more specific provisions are likely to minimize the time and expense of post-award contract modifications. Some study states are bringing in third-party consultants or vendors to help with requirements drafting.

While study states report attempts to be highly specific, they note that projects of this magnitude often take years to plan and implement, going through several iterations along the way. In addition, there remains uncertainty regarding final ACA rules and how states will implement them. Therefore, study states also recommend that proposal requests include open-ended provisions to accommodate the fluid policy environment. A few study states adopted a menu approach for unanswered questions: vendors price each menu option according to their approach; states review and decide whether to pursue the menu item or take it off the table. The risk to this procurement approach is that vendors are taking the lead on defining detailed system requirements and vendor uncertainty may lead to higher pricing. Others study states' RFPs outline items required by ACA for 2014 and list other possible enhancements for states to purchase at a later date.

Be transparent with internal and external stakeholders to clarify and manage expectations.
Modernization efforts underway in study states involve and will benefit more than one government agency as well as several levels of staff and they are taking different steps to share information and request feedback. For example, some study states involved external stakeholders (such as consumers, providers, advocates, and payers) early in the procurement process by convening them to review early RFP drafts. The expectation among these study states is that transparency reduces the need for future scope changes and improves customer satisfaction. Another study state began educating internal technical and business staff about revised processes and supporting technological advancements before vendor selection to raise awareness and answer questions.

Build staff education and training into procurements.
A few study states reported building into their contracts with vendors the need to educate and train existing staff, such as eligibility workers and information technology staff, in new system terminology and processes.

Select vendors with sufficient knowledge and expertise to deliver.
Eligibility system changes are complicated undertakings; many study states stressed the importance of working with highly qualified vendors with hands-on experience. Examples of vendor strengths provided by a subset of respondents include: leaders and managers with knowledge and experience developing similar systems in other states; efficient and effective consultants who can implement change without interfering with ongoing operations; subject matter experts who are capable of presenting and delivering viable design options and risks using the latest technology and rooted in current research, regulations, as well as customized to state-specific considerations.

B. Preparing Medicaid Eligibility Systems for 2014 and Beyond

All study states responded that they are planning to or are in the process of making changes to their existing Medicaid eligibility systems to achieve ACA and/or CMS goals as well as to realize state plans for system improvement. The study states are at varying stages of planning and implementation, and many of them must phase in their upgrades rather than see them all realized in January of 2014. Provided below is an overview of study states' plans and timelines for system changes, integration, and interaction with Exchanges.

Most Study States Plan to Design and Implement New Systems

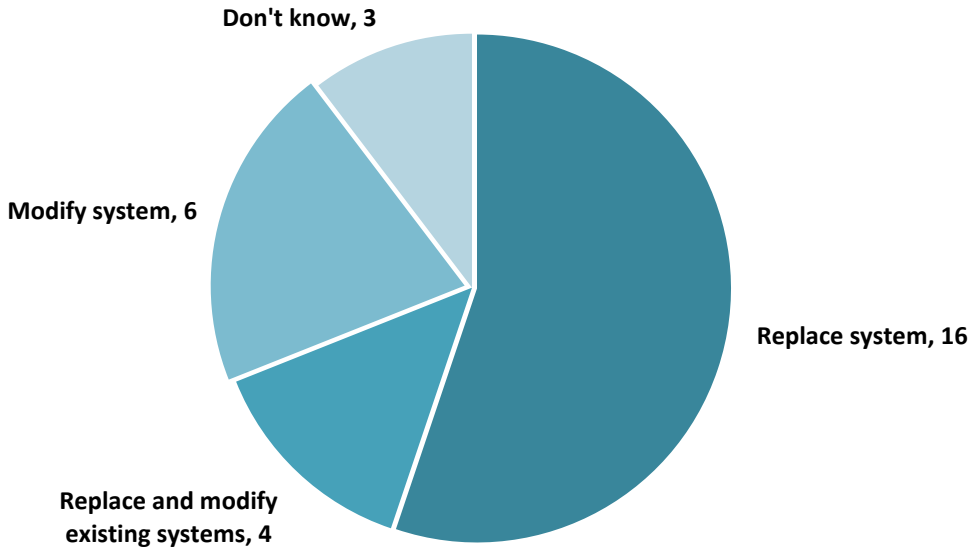
Twenty study states plan to replace all or part of their existing systems that support Medicaid eligibility determination; 10 such systems date back to the 1970s and 1980s. Some study states are taking a "build it for Medicaid first" or "built it for Medicaid and other public programs, e.g., SNAP and TANF, first" approach, and others are taking a "build it for the Exchange first" approach. Several study states expected to fully integrate eligibility functionality for Medicaid and Exchange programs (if applicable) and other public programs in their replacement systems at a later point.

Exhibit 7 shows that four study states report plans for a combination of replacement and modification. Two of these study states are modifying existing systems (built in the 1990s) to accommodate MAGI-eligible populations by the October 2013 enrollment deadline, while also preparing for a phased replacement of remaining systems (reusing new MAGI rules) under the more realistic CMS matching funds deadline. The other two of these study states plan to install new Exchange systems for MAGI eligibility determination and enhance their legacy Medicaid eligibility systems to support "real time" eligibility determination via Internet services and through interfaces to the new Exchange system.

Six states report plans to modify existing systems rather than replace them. Many of these states already had system enhancement plans in place before ACA, which they subsequently tweaked to ensure ACA compliance.

Three states, for political and other reasons, were unable to articulate their approach to modernization at the time of the survey discussions. Some of these mentioned identifying ways to simplify extensive processes and systems and documenting associated business requirements to support eligibility simplification.

Exhibit 7: Planned Medicaid Eligibility System Changes among Study States



Note: Missing data for one state that did not complete Part 2 of the survey.

Factors Considered by States in Determining Extent of System Modernization

States noted a number of factors that are influencing their decision making on changes to their Medicaid eligibility systems, including:

- System age and capacity to accommodate further upgrades.
- Available resources (time, staff, dollars) and executive-level commitment to system change. While not specifically addressed, it should be noted that 4 of 13 states filing lawsuits to challenge ACA are planning to replace their systems, compared to 12 of 17 states that are not filing.
- Degree of system integration currently and desired.
- Ability to address and respond to evolving customer and partner needs.
- State willingness to accept client self-declaration.
- Extent to which systems are overseen by more than one agency and identifying which agency is taking lead responsibility.
- Extent to which systems will support or interface with a state or federal Exchange; and
- Nature of interaction with other information sources.

Some study states mentioned that vendors, through RFI processes, have helped them think through the options for replacement systems. These options commonly include:

- transfer system, meaning a system developed in another state that can be purchased and customized, e.g., Michigan's Bridges integrated eligibility system, Wisconsin's CARES integrated eligibility system and Wisconsin's ACCESS front door;
- Commercial Off The Shelf (COTS) system, with lower up-front development costs but long-term licensing and customization costs; and
- custom system, which may take longer to design and implement.

Planned System Changes Consistent with ACA Provide States with Opportunities

Study states are embarking on huge, multi-year system design and implementation projects. While these states are scrambling to respond to health reform law requirements and/or CMS' seven conditions and standards guidelines, they are also revisiting business requirements for Medicaid and other programs (from multiple user perspectives) and planning hardware, software, and system solutions to meet as many of them as possible.

Of course, a primary goal of system changes for many study states is to support real-time eligibility determination for the MAGI Medicaid population through an automated, Internet-enabled flexible, interface, consistent with ACA demands. Examples of changes to system technology that study states are planning include:

- moving to a web-based platform;
- employing Service Oriented Architecture and Enterprise Service Buses (where an eligibility system consists of business rules and services stored separately and can call upon multiple services and serve multiple programs efficiently);
- acquiring new or enhancing existing rules engine software (rules are housed in decisions tables to allow for programming change with minimal programmer intervention and Corticon rules engine product was cited more than once by study states);
- enhancing electronic verifications including data retrieval; and
- acquiring master client index products (creates master repository for client demographic data).

Many study states also envision a customer portal to put more information into the hands of the applicants. Related changes planned or in progress include:

- online applications that directly populate eligibility systems to support "real-time" determinations;
- improved self-service functionality (e.g., ability to report changes, look up information, and calculate benefits);
- expanded notice capability (e.g., text and email); and
- interactive voice response to allow user interaction with the system by speech recognition over the phone.

Most study states intend to capitalize on the new system architecture and functionality for non-MAGI Medicaid categories and other human service programs. For example, they are anxious to use information technology to ensure that eligibility rules are applied consistently across applicants. In addition, they are considering implementing third party verification processes for non-MAGI populations.

Several study states are using this opportunity to address other issues, as well, such as:

- enhancing portals used by eligibility staff to provide centralized access to applicant information and facilitate determination;
- improving case management functionality to better manage coverage transitions;
- supporting electronic document imaging and management solutions;
- making security enhancements;
- offering new data warehouse business intelligence services for improved reporting; and
- creating seamless and automated interfaces with other internal (e.g., MMIS and accounting) and external (e.g., Exchange) systems.

Study States' ACA Implementation Planning Varies

Most study states are gearing their plans according to ACA requirements, CMS enhanced funding deadlines, and vendor inputs. ACA calls for states to be ready to enroll MAGI Medicaid populations, among other Exchange populations, by October 2013 (with "readiness" tests in July 2013), and be fully operational by January 2014. "90/10" funding from CMS and the associated cost allocation waiver expires in December of 2015. Vendors, according to some study respondents, are suggesting a phased approach to Medicaid eligibility system modernization, with initial implementation of solutions for MAGI populations (to meet ACA deadlines), followed soon by non-MAGI solutions, and finally other human service program solutions, if applicable.

Eight states report that they hope to achieve their goals for system modernization by January 2014. Most of these study states are planning to implement integrated eligibility systems, but recognize that their expectations are ambitious given the magnitude of changes required under the tight timeline. Five states report plans to accommodate all of the Medicaid eligibility requirements by the ACA deadline, including MAGI Medicaid, CHIP, and the non-MAGI populations, phasing in the integration of other human services programs later. Ten study states report phasing implementation, with plans to accommodate only the MAGI Medicaid population under their system changes by January 2014 or earlier.[14] Six study states were unable to forecast their timeline for modernized systems to go live at the time of the survey discussions.

By December 2015, an additional 10 study states expect to achieve their goals for system modernization (integration of non-MAGI and/or other human services programs and/or other technological

[14] Those newly-eligible under the MAGI criteria will earn a higher federal medical assistance percentage (FMAP), 100 percent through 2016, after which it will decline in steps to 90 percent by 2020. Further information is described in Au-Yeung, C. and John Czajka. 2011. "Modified Adjusted Gross Income: Implications for Medicaid Eligibility Systems under the ACA." Minneapolis, MN: State Health Access Reform Evaluation, available at http://www.shadac.org/files/shadac/publications/ACA%20Note_MAGI_FMAP.pdf

advancements). Five study states expect that they will need more time to roll out fully integrated eligibility systems.

Most study states interviewed (26) were at various stages of modernization implementation at the time of data collection. We approximate that 10 study states were in the planning phase (identifying business and technical requirements, requesting information from vendors and other states, conducting information technology assessments) and 7 states were actively procuring vendor services to modernize systems or to develop new Exchange systems. Nine study states had begun system design and implementation. Note that not all states are using a vendor.

Most Study States Want New Systems to Comprehensively Support Medicaid

While eligibility rules for the non-MAGI populations will not be changed by ACA, this study asked states if their modernized eligibility systems will nonetheless support eligibility determination for this Medicaid population (roughly 25 percent of all Medicaid enrollees).[15] Twenty-two study states report plans to support eligibility determination for non-MAGI Medicaid populations in replaced or modified systems. However, as mentioned above, in many study states incorporation of non-MAGI populations into transformed systems is phased and will take place only after MAGI population approaches are accounted for. Six study states were undecided at the time of discussions. Only one study state does not plan to integrate non-MAGI applicants into its new Exchange system; it will continue to support this population in updated integrated eligibility systems.

There is recognition among study states that eligibility determination for non-MAGI Medicaid populations will not be "real time" or fully automated. Study states note that traditional Medicaid requirements for the ABD and other non-MAGI populations are typically more resource-intensive than those under new-MAGI rules. Income and asset tests, as well as spend-down provisions, call for paper documentation and expert reviews. Some respondents also commented that these populations often prefer to submit paper applications, request face-to-face discussions with workers, and are eligible for other public benefit programs. A subset of states follow stricter rules for Medicaid eligibility than are used for Supplemental Security Income (SSI), which presents a barrier for electronic verification of these populations through data exchanges with the Social Security Administration (the agency that determines SSI eligibility).[16]

In several study states, eligibility determination for the non-MAGI population will remain unchanged in the short run. Legacy systems will continue to support this population. In the long run, study states see integrating the non-MAGI population as an opportunity to create more efficient and accurate determinations, improve customer service, and better manage workflow (for example, automated case assignment to available and appropriate workers). One study state hopes to automate level of care

[15] Weiss, A.M. and L. Grossman. 2011. "Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today." Washington DC: National Academy for State Health Policy, available at http://www.nashp.org/sites/default/files/bridging.state_.gaps_.pdf.

[16] Supplemental Security Income (SSI) beneficiaries (cash benefit for low income individuals who are aged, blind, and/or disabled) are automatically eligible for Medicaid and the comprehensive package of health care benefits. Eleven states (including five the of study states), are known as 209b states; they have more restrictive criteria for Medicaid eligibility than are used in the SSI program. More states are known as 1634(a) states, meaning they have a contract with the SSA to determine eligibility for Medicaid at the same time a determination is made for the receipt of SSI benefits and use the same criteria for determining eligibility as SSI.

determinations (state-specific criteria based on federal guidelines to determine who meets medical eligibility for institutional care programs).

Regardless of the implementation timeline, several study states cited the importance and efficiency of precise screening and tracking of non-MAGI populations due to the high likelihood of crossover eligibility with Exchange populations. Exchange populations may have health conditions serious enough to meet an applicable disability. Therefore, sophisticated communication between Medicaid eligibility and Exchange eligibility systems (if they are not the same system) is critical to identify these individuals so that they receive the broader benefits for which they are eligible.[17]

Study states provided insights into current thinking on how and when to screen for non-MAGI and incorporate them into system changes:

- Leverage non-MAGI rules currently part of legacy systems to use in new, separate rules engines.
- Develop a single streamlined application that is sensitive enough to flag non-MAGI populations so that they can be properly forwarded to the appropriate eligibility determination process and system regardless of entry point.
- Ensure a seamless transfer of screened eligibles between Exchanges and other systems.

States provided examples of different screening pathways under discussion:

- Determine eligibility first based on state rules for programs offering the highest level of benefits; i.e., the non-MAGI populations. If individuals are not eligible, applicants will be evaluated by a rules engine implemented for the new Medicaid groups using the MAGI methodology.
- Determine MAGI Medicaid eligibility initially and interface (to varying degrees) with legacy or modernized systems for subsequent eligibility determination for other Medicaid categories.

Some of the study states that are still deciding if they will incorporate non-MAGI Medicaid groups into their system reforms are discussing whether to modify existing systems or to address this population in a new system, and how to change eligibility logic, among other issues. They await federal direction on these and related topics, such as criteria for enhanced FMAP claiming and contents of the federal data "hub".

[17] Rosenbaum, S. and T. Riley. 2012. "Building a Relationship between Medicaid, the Exchange and the Individual Insurance Market. Report from the Study Panel on Health Insurances Exchanges created under the Affordable Care Act." Washington DC: National Academy of Social Insurance.

Horizontal Integration of Other Human Service Programs Is Envisioned But Not by ACA Deadline

As described earlier, SHADAC's review of eligibility system characteristics confirms that most study states support other human service programs in their current eligibility systems. While the vision among most study states is to continue to support horizontally-integrated eligibility systems (Medicaid MAGI, non-MAGI and Exchange health insurance programs as well as other human service programs), only a minority of study states report plans to achieve this goal by ACA deadlines. Several study states noted that the time-limited exception to cost allocation requirements associated with enhanced funding from CMS motivated them to maintain horizontal integration.

Overall, it appears that more systems are expected in the short-run to support eligibility determination of Medicaid populations. Almost half of study states with integrated eligibility systems currently report plans to support fewer public programs in their system changes in the short term, with the exception of a few instances of CHIP integration. Most system enhancements are being designed, where possible, to accommodate other public programs having different and in some cases stricter rules. Study states expect to return to integrated systems by 2015 or beyond. Study states with stand-alone Medicaid eligibility systems report plans to either maintain or increase the number of programs, including non-health programs.

Half of Study States Plan to Leverage Modernized Medicaid Eligibility Systems as Platforms for Exchange Eligibility Determination

Study states are either participating in or actively monitoring state discussions regarding pursuit of state Exchanges while modernizing their eligibility systems. Seventeen study states reported that their state was planning to create a state Exchange. Eleven of the study states were unsure at the time of the survey discussions. Two study states reported plans to use the Federal Exchange.

ACA requires coordination between state Medicaid agencies and Exchanges. Among study states pursuing a state Exchange, the degree of collaboration between Medicaid eligibility system modernization and Exchange planning efforts varies. Some respondents described the efforts as well-integrated, with the ultimate goal of a single eligibility system for Medicaid and other subsidized coverage options. In a couple of these states, Medicaid and CHIP agencies serve on Exchange governing bodies or oversee aspects of Exchange planning. Some survey respondents view the two efforts as separate projects working in tandem, and maintain regular communication between project teams with plans to build data sharing functionality into the architecture of both systems. Some study states referred to future Memoranda of Understanding (MOUs) to outline working relationships between Medicaid and Exchange bodies. With respect to data storage and flow for states with separate eligibility systems, a couple of study states imagined a "push-pull" strategy such that Medicaid provides the Exchange with updates and the Exchange provides Medicaid with updates in real time.

As shown in Exhibit 8, 14 study states expect that their current or transformed Medicaid eligibility system will also support subsidy eligibility determination for the proposed Exchange (11 of these 14 states reported pursuit of a state Exchange). Beyond the 14 mentioned above, 8 study states did not know their plans at the time of the survey, and 5 study states did not expect their eligibility systems for Medicaid to serve as the eligibility platform for state Exchanges.

Exhibit 8: Modernized Systems Also Eligibility Platform for Exchanges

	System that Supports Medicaid Eligibility Also Supports Exchange Eligibility				
Plans for Meeting Exchange Requirements	**Yes**	**No**	**Do not know**	**Not applicable or no response**	**Total**
Create a state exchange WITH federal funding	11	4	1	--	16
Create a state exchange WITHOUT federal funding	--	--	1	--	1
Do not know	3	1	6	1	11
Use the Federal exchange	--	--		2	2
Total	**14**	**5**	**8**	**3**	**30**

Study States Indicated a Desire to Learn from the Experiences and Planning by Other States

During survey discussions, study states referenced published RFPs and responses to RFIs as valuable resources in early stages of planning. Study states have been communicating with CMS representatives at the federal and regional level, have conducted site visits, and have participated in national conferences to gain insights. A few study states pursuing state Exchanges are also Early Innovator and/or Enroll UX 2014 project grantees; participation in these communities has provided valuable opportunities for learning and sharing.[18] Two study states noted that HHS has established the CALT website, a social platform for organizations and individuals partnering and working with CMS to collaborate (https://calt.hhs.gov).

[18] The Enroll UX 2014 project is focused on a "human-centered user experience (UX) design for health insurance exchanges" and the concept of reusability in terms of knowledge, artifacts/documentation, and ultimately software components. Information is available at http://www.ux2014.org/

VI. Discussion

Medicaid eligibility system modernization projects represent huge undertakings for states but are expected to yield significant benefits. Existing systems store millions of records and thousands of business logic commands for Medicaid and other public programs; many state agencies, despite their best intents, have not been able to keep up with changes in information technology to improve system performance and functionality. Extensive employee training is required to use legacy systems, program and policy changes are difficult to accommodate in current systems, and few systems were designed with customer service in mind.

Efforts to upgrade outdated eligibility systems predate ACA. A handful of study states described previous attempts to replace their eligibility systems or decade-long discussions about the need to update aging technology. Barriers to implementation included lack of funding, lack of awareness of the investment needed for system changes, lack of executive-level commitment, interest in upgrading MMIS before eligibility systems, and/or lack of staff expertise. As was reported earlier, 20 study states successfully implemented system changes beyond routine maintenance in the last 10 years, in the form of system modifications or total system replacements. Even among the study states with newer systems, major enhancements are needed to address ACA requirements for the newly designated MAGI population as well as to continue to support non-MAGI Medicaid and other human services programs. Moreover, data ownership issues cannot be underestimated as evidenced by some study states' reporting of barriers to accessing external state data sources for electronic verification of applicant information.

Other challenges noted by study states with respect to modernizing integrated eligibility systems include the need to involve multiple agencies in the decision making process. Also, investments in state-of-the-art, modular information technology can be significant and underscore the importance of convincing leaders of the business case for multi-year, and in many cases, multi-million dollar system change efforts.

System upgrade timing is an issue as states are attempting to make decade's worth of upgrades in less than two years.[19] Most study states anticipate having a functional eligibility system for the MAGI population by 2014, but many forecast a staged expansion of functionality and programs supported after that deadline. Some study states in the planning stages of system replacement efforts may decide to buy a transfer system used by another state or off-the-shelf system rather than build to their specifications due to tight time constraints. Almost all study states have expressed frustration with the slow rate of guidance provided by the federal government regarding details such as the federal data hub and Exchange options.

Study states are operating in uncertain environments; therefore, the indecision among study states with respect to an integrated Exchange platform (including where data will reside) is expected. For example, states that are modernizing eligibility systems – but do not have clear direction regarding the state's plans for an Exchange – hope to reuse the newly-developed rules engines if a decision to develop a state

[19] Kaiser Commission on Medicaid and the Uninsured. 2012. "Briefing, Survey Examine 2012 Data From 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Policies." January 18, 2012 briefing archive, at http://www.kff.org/medicaid/Briefing-2012-Data-50-State-Survey-Medicaid.cfm, accessed January 20, 2012.

Exchange is made. Exchange provisions are being written into some Medicaid eligibility system procurements as potential options for states to buy. Study states report preparing for multiple contingencies in their system design efforts so that, when decisions are finalized, implementation can begin ("plug and play" approach). Study respondents in states planning to use the federal Exchange plan to work with federal government to leverage system enhancements.

Despite the complexities of system changes, study states (and vendors) are working fervently to implement the required changes in the short term, and phase in integrated eligibility system solutions over the long run. The availability of federal matching funds is critical to the states' progress toward and realization of the benefits of system updates.

National health care reform calls for Medicaid eligibility simplification for nearly the entire Medicaid program, but several issues remain for states to consider regarding how to best leverage system modernization across other populations and to address other needs. While it remains to be seen how these issues apply for non-study states, some of the key considerations at least for the study states are:

- Managing stakeholder expectations regarding what can be accomplished by states and vendor partners, and by when.
- Removing barriers in the procurement process, including sole-source contracting, in order to accomplish the magnitude of required changes in the short time frame.
- Revisiting business processes for eligibility determination of the non-MAGI Medicaid populations to find opportunities for simplification and automation from the customer and worker perspectives.
- Creating seamless interfaces between new eligibility and/or Exchange systems and legacy systems for screening and data sharing purposes because most replacement system implementation is phased and multiple systems will be operating in the short run.
- Ensuring that a streamlined application is sufficiently sensitive to flag for a variety of public programs and that system linkages ensure that cases are transferred to the appropriate system regardless of entry point.
- Determining how best to transition from legacy to transformed systems, and whether and how to retire legacy systems. Most respondents do not envision a "flip the switch" transition; rather, a staged approach; i.e., by program, geography, etc.
- Assessing how Medicaid eligibility system modernization efforts fit into broader state information technology goals; e.g., enterprise solutions and health information exchanges.
- Building into system upgrades functionality for improved reporting, metrics and data accessibility.

VII. Conclusion

The SHADAC SHAP Medicaid Eligibility System survey provides a snapshot of 30 study states and provides perspective into their efforts to upgrade Medicaid eligibility systems in light of national health reform requirements. Study states are coming from a variety of starting points but it is clear that most need a significant overhaul of their eligibility systems. Most study states plan to create new systems to address required federal eligibility system reforms and state business priorities. In many cases systems will become integrated eligibility systems, supporting eligibility determination for new MAGI and other Exchange populations as well as non-MAGI Medicaid populations and those applying for other public programs, such as SNAP and TANF. About one quarter of study states report plans to accomplish ambitious system integration goals by the January 2014 deadline. The remaining study states plan to phase in implementation of integrated eligibility systems by the enhanced CMS funding deadline. In addition, almost half of the study states expect replacement or modification efforts to further support eligibility determination for a state Exchange, if applicable. With final ACA Medicaid and Exchange eligibility rules recently released, all states will benefit from continued opportunities to learn, discuss, and share with the ultimate goal of successful eligibility system modernization efforts.

Appendix A: Study States

State	
Alaska	
California	
District of Columbia	
Georgia	
Hawaii	
Illinois	
Indiana	
Kansas	SHAP Grantee
Kentucky	
Louisiana	
Maryland	
Massachusetts	
Michigan	
Minnesota	SHAP Grantee
Mississippi	
Nebraska	
Nevada	SHAP Grantee
New Hampshire	
New Jersey	
New Mexico	
New York	SHAP Grantee
North Dakota	
Ohio	
Oklahoma	
Oregon	SHAP Grantee
Tennessee	
Texas	SHAP Grantee
Virginia	SHAP Grantee
West Virginia	SHAP Grantee
Wyoming	

Appendix B: SHADAC SHAP Medicaid Eligibility System Survey Form

shadac
State Health Access Data Assistance Center
Bridging the gap between research and policy

Survey of State Medicaid Directors on Eligibility System Changes

December 2011/January 2012

Dear State Medicaid Directors:

Thank you for agreeing to participate in this survey about state Medicaid eligibility systems. We realize that your agency is extremely busy running health insurance programs as well as planning for expanded Medicaid enrollment (whether early or in 2014) and responding to Medicaid Information Technology Architecture, among other activities.

The State Health Access Data Assistance Center (SHADAC) is conducting this brief survey in all 50 states to study and share recent efforts by State Medicaid Agencies to transform their systems to support individual eligibility determination processes called for under national health reform. SHADAC's intent is to facilitate learning across states to support data and system development and implementation.

There are two parts to the survey.

- *Part 1 includes questions about your current computer systems and your understanding of initial plans in the state for the Affordable Insurance Exchange. The first part of the survey should take no more than 10 minutes to complete. It can be completed by you or someone you designate as an electronic form or printed out and filled in by hand.*

- *Part 2 includes questions about planned system modifications that we will discuss during a scheduled 15-30 minute telephone conversation with you or a select designee.*

Please complete, verify and/or correct Part 1 of the survey in advance of the scheduled telephone discussion, if possible. Please save or scan your responses and return the completed form to Karen Soderberg at SHADAC via e-mail (soder145@umn.edu) or fax (612-624-1493).

We are available by phone or e-mail if you have any questions or concerns.

Sincerely,

Karen Soderberg, MS
Research Fellow, SHADAC
612-625-5062
soder145@umn.edu

Christina Andrews Worrall, MPP
Consultant to SHADAC
571-334-2306
worrall.christina@gmail.com

cc: Lynn A. Blewett, PhD
Director, SHADAC

Please verify or provide your information:

State: _____

Respondent name: _____ Respondent (2): _____

Title: _____ Title (2): _____

Agency name: _____ Agency name (2): _____

If needed, please list additional respondents here: _____

Part 1 - System Characteristics

The following questions address key characteristics of your current Medicaid eligibility system.

1. Please identify and describe the primary computer system used by Medicaid staff to support current individual Medicaid eligibility determination and/or tracking in your state.

1a. System Name | |

1b. Year System First Implemented | |

1c. Does your current Medicaid eligibility system run on a mainframe or web-based environment? *(Select one by typing an X in the left box)*

	Mainframe System
	Web-based System
	Other (*please specify*)

1d. Does your current Medicaid eligibility system support cases (or applicants) for the entire state or part of the state? *(Select one)*

	State
	Local or Regional *(please describe)*
	Other (*please specify*)

1e. What entity manages your current Medicaid eligibility system and oversees the budget? *(Select one)*

	State Medicaid Agency
	Other State Agency (*please specify)*
	Vendor or other (outside of government) organization (*please describe)*
	Other (*please specify*)

2. Briefly describe your state's current Medicaid eligibility determination process (e.g., manual and/or automated; decentralized and/or centralized)

3. Please identify all of the programs for which individual eligibility is determined and/or tracked through your current Medicaid eligibility system. *(Select all that apply)*

	Medicaid		Public Health (non-Medicaid)
	CHIP		Child Care
	SNAP		Child Support
	TANF		Housing
	Mental Health (non-Medicaid)		
	Other health insurance programs *(please specify)*		
	other non-health insurance programs *(please specify)*		

4. Has your current Medicaid eligibility system been modernized in the last 10 years? *Modernization refers to system replacement, major system modifications (meaning major changes to the system front end, e.g., online portals, back end, e.g., data warehouse, and/or functionality, e.g., electronic application, verification, determination, notification, or renewals), and/or the implementation of electronic tools that interface with the system to facilitate Medicaid eligibility determination.*

(Select all that apply)

	Yes, system replacement
	Yes, major system modification (*please explain system change and programs affected)*
	Yes, implementation of interface tools to facilitate Medicaid eligibility determination (*please explain enhancement and programs affected)*
	No modernization other than maintenance updates
	Do not know

5. Which of these automated functionalities does your current Medicaid eligibility system have, if any? *(Select all that apply)*

	Determines eligibility electronically
	Verifies eligibility electronically
	Re-determines eligibility electronically
	Tracks eligibility electronically and serves as a data repository (eligibility determination, verification and re-determination are conducted manually and entered into the system for tracking purposes)
	Other (*please specify)*

6. What vendors have you used in the last ten years to modernize your current Medicaid eligibility or other Medicaid systems, e.g., MMIS. *(Select one)*

	No vendor use
	Vendor name(s) (*please identify vendor names and the Medicaid systems involved)*
	Do not know

7. As a proxy for the volume your system handles, please approximate the number of individuals enrolled in Medicaid for your most recent Fiscal Year. *(Please indicate whether CHIP is included)*

Or, if acceptable, please verify Fiscal Year 2008 Total Medicaid Enrollment

[Source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2011. Accessed at http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4]

8. We are interested in an assessment of how well the current Medicaid eligibility system meets State Medicaid Agency policy and program needs. Please provide examples of needed functionality not included in your current system.

9. As a proxy for the additional volume Medicaid eligibility systems will support, how many individuals are projected to be newly eligible for Medicaid under ACA?

Or, if acceptable, please verify January 2010 newly eligible estimates extending eligibility to 133 percent of the FPL.

(Source: Holahan, John and Linda Blumberg. How Would States Be Affected By Health Reform? Timely Analysis of Immediate Health Policy Issues January 2010. An Urban Institute analysis of 2007-2008 Current Population Surveys. Accessed at http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf)

The remaining questions in Part 1 of the survey relate to your current understanding of the state's decision making related to implementation of an Affordable Insurance Exchange.

10. Please verify the agency overseeing the planning process for the Affordable Insurance Exchange (Exchange).

11. What is your current understanding of how your state is planning to meet federal requirements for an Exchange? *(Select one)*

	Create a State Exchange (or modify an existing one) with federal funding
	Create a State Exchange (or modify an existing one) without federal funding
	Create a Subsidiary Exchange
	Create or join a Regional Exchange
	Use the Federal Exchange
	Participate in a Federally Facilitated Exchange or State Partnership Model, such that the Exchange is jointly run by the State and the U.S. Department of Health and Human Services
	Do not know

12. What entity will house the Exchange data? *(Select one)*

	State Medicaid Agency
	Other Government Agency *(please specify*
	Vendor or other (outside of government) organization *(please describe)*
	Other (*please specify)*
	Do not know

13. Please verify recent federal Exchange grant awards.

Thank you for completing the first part of this survey. We look forward to a follow up telephone conversation.

Part 2 – Discussion Questions About State Medicaid Eligibility System Modifications
(Please do not complete this portion of the survey---to be conducted by phone.)

2-1. Are you in the process of making or planning to make changes to [system name from Part 1 Question 1] in light of national health reform?

	Yes
	No
	Do not know

2-2. If yes, will you modify your current Medicaid eligibility system or replace it?

	Replace
	Modify
	Do not know

2-3. Please describe the changes in progress or planned. *Probe for changes to the system technology (e.g., hardware, software, platform, and architecture), front end (e.g., online portals), back end (e.g., data warehouse), and functionality (e.g., electronic application, notification, and renewal for consumers, electronic verification and determination, third party assistance, ELE). Probe about program integration and state collaboration.*

2-4. What is the timeline for implementing system changes? Which changes will be completed by January 2014?

2-5. IF VENDOR USED, OTHERWISE SKIP TO QUESTION 16: You identified in the first part of the survey that you worked with _____ vendors. How will your past vendor experiences inform future procurement decisions related to modernization of eligibility systems to be compliant with ACA? Generally speaking, where are you in your procurement process to facilitate modernization of your eligibility system, if applicable?

2-6. Do you expect your current or transformed system that supports Medicaid eligibility determination to also support eligibility determination for the proposed Exchange?

	Yes
	No
	Do not know

2-6a. If No, do you know whether your state is planning to:

	Build a new eligibility system for the Exchange
	Modify an existing system (if so, which one)
	"Buy" the federal system
	"Borrow"/"rent" another system (if so, which one)

	Do not know

2-7. What is your state's current vision for Exchange governance? *Probe on whether the entity overseeing Exchange planning will govern the Exchange. Probe for factors influencing decision making on Exchange governance, management, and data storage and use.*

2-8. Are you addressing eligibility determination of Medicaid recipients whose eligibility is not determined by the new modified adjusted gross household income (MAGI) criteria in your system changes? If so, how? If not, why not?

	Yes *(please explain)*
	No *(please explain)*
	Do not know

2-9. In the near future, SHADAC hopes to investigate how States are using or plan to use data stored in modernized eligibility systems to respond to federal and state reporting requirements. Could you please recommend the right person to talk to in your state about querying system data to respond to reporting requirements and for monitoring, evaluation and planning purposes? With what entity is this person affiliated?

Name	
Agency (and title)	
Email and/or phone	

Thank you for your time and insight.

Appendix C: Closed-Ended Question Response Counts

Part 1 - System Characteristics

The following questions address key characteristics of your current Medicaid eligibility system.

1. Please identify and describe the primary computer system used by Medicaid staff to support current individual Medicaid eligibility determination and/or tracking in your state.

1a. System Name

See Appendix C

1b. Year System First Implemented

2	1970's
10	1980's
13	1990-2001
5	2002 or newer

1c. Does your current Medicaid eligibility system run on a mainframe or web-based environment?

23	Mainframe System
4	Web-based System
3	Other (e.g., both types of systems)

1d. Does your current Medicaid eligibility system support cases (or applicants) for the entire state or part of the state? *(Select one)*

28	State
2	Local or Regional
0	Other

1e. What entity manages your current Medicaid eligibility system and oversees the budget? *(Select one)*

6	State Medicaid Agency
14	Other State Agency
0	Vendor or other (outside of government) organization
10	Other

3. Please identify all of the programs for which individual eligibility is determined and/or tracked through your current Medicaid eligibility system. *(Select all that apply)*

30	Medicaid
22	CHIP
23	SNAP
24	TANF
1	Public Health (non-Medicaid)
10	Child Care
3	Child Support
1	Housing
3	Mental Health (non-Medicaid)
6	Other health insurance programs
11	Other non-health insurance

4. Has your current Medicaid eligibility system been modernized in the last 10 years? *(Select all that apply)*

5	Yes, system replacement
5	Yes, major system modification
12	Yes, implementation of interface tools to facilitate Medicaid eligibility determination
10	No modernization other than maintenance updates
0	Do not know

5. Which of these automated functionalities does your current Medicaid eligibility system have, if any? *(Select all that apply)*

22	Determines eligibility electronically
12	Verifies eligibility electronically
19	Re-determines eligibility electronically
22	Tracks eligibility electronically and serves as a data repository (eligibility determination, verification and re-determination are conducted manually and entered into the system for tracking purposes)
6	Other

6. What vendors have you used in the last ten years to modernize your current Medicaid eligibility or other Medicaid systems, e.g., MMIS. *(Select one)*

5	No vendor use
24	Vendor names *(See Appendix D)*
1	Do not know

7. As a proxy for the volume your system handles, please approximate the number of individuals enrolled in Medicaid for your most recent Fiscal Year. *(Please indicate whether CHIP is included)*

   Or, if acceptable, please verify Fiscal Year 2008 Total Medicaid Enrollment *(See Appendix E)*

8. We are interested in an assessment of how well the current Medicaid eligibility system meets State Medicaid Agency policy and program needs. Please provide examples of needed functionality not included in your current system. *See Appendix F*

9. As a proxy for the additional volume Medicaid eligibility systems will support, how many individuals are projected to be newly eligible for Medicaid under ACA?

   Or, if acceptable, please verify January 2010 newly eligible estimates extending eligibility to 133 percent of the FPL. *(See Appendix E)*

11. What is your current understanding of how your state is planning to meet federal requirements for an Exchange? *(Select one)*

16	Create a State Exchange (or modify an existing one) with federal funding
1	Create a State Exchange (or modify an existing one) without federal funding
0	Create a Subsidiary Exchange
0	Create or join a Regional Exchange
2	Use the Federal Exchange
0	Participate in a Federally Facilitated Exchange or State Partnership Model, such that the Exchange is jointly run by the State and the U.S. Department of Health and Human Services
11	Do not know

12. What entity will house the Exchange data? *(Select one)*

0	State Medicaid Agency
6	Other Government Agency
2	Vendor or other (outside of government) organization
6	Other
16	Do not know

Part 2 – Discussion Questions About State Medicaid Eligibility System Modifications

Note: this section has one non-respondent; totals add to 29.

2-1. Are you in the process of making or planning to make changes to [system name from Part 1 Question 1] in light of national health reform?

29	Yes
0	No
0	Do not know

2-2. If yes, will you modify your current Medicaid eligibility system or replace it?

16	Replace
4	Both modify and replace
6	Modify
3	Do not know

2-6. Do you expect your current or transformed system that supports Medicaid eligibility determination to also support eligibility determination for the proposed Exchange?

14	Yes
5	No
8	Do not know

2-6a. If No, do you know whether your state is planning to:

0	Build a new eligibility system for the Exchange
0	Modify an existing system (if so, which one)
1	"Buy" the federal system
0	"Borrow"/"rent" another system (if so, which one)
4	Do not know

2-8. Are you addressing eligibility determination of Medicaid recipients whose eligibility is not determined by the new modified adjusted gross household income (MAGI) criteria in your system changes? If so, how? If not, why not?

22	Yes
1	No
6	Do not know

Appendix D: Names of Primary Medicaid Eligibility System(s) in Study States

State	System Name
Alaska	Eligibility Information System (EIS)
California	CalWORKs Information Network (CalWIN); LEADER; Consortium 4 (C-IV)
District of Columbia	Automated Client Eligibility Determination System (ACEDS)
Georgia	System for Unified Calculation and Consolidation of Economic Support Services (SUCCESS)
Hawaii	HAWI
Illinois	Client Information System (CIS)
Indiana	Indiana Client Eligibility System (ICES)
Kansas	Kansas Automated Eligibility and Child Enforcement System (KAECSES)
Kentucky	Kentucky Automated Management and Eligibility System
Louisiana	Medicaid Eligibility Data System (MEDS)
Maryland	Client Automated Resource Eligibility System (CARES)
Massachusetts	MA21
Michigan	Bridges
Minnesota	MAXIS/MEC²
Mississippi	MEDS (Aged & Disabled programs); MEDSX (Families/children programs and CHIP)
Nebraska	Nebraska Family Online Client User System (N-FOCUS)
Nevada	NOMADS
New Hampshire	New Heights
New Jersey	Medicaid Eligibility System (MES)
New Mexico	ISD2
New York	Welfare Management Systems
North Dakota	Vision; TECS
Ohio	Client Registry Information System – Enhanced (CRIS-E)
Oklahoma	Medicaid Management Information Systems (MMIS)
Oregon	Client Maintenance System
Tennessee	Automated Client Certification and Eligibility Network for TN (ACCENT)
Texas	Texas Integrated Eligibility Redesign System (TIERS)
Virginia	Application Benefit Delivery Automation Project (ADAPT)
West Virginia	Recipient Automated Payment and Information Data System (RAPIDS)
Wyoming	Eligibility Payment Information Computer System (EPICS)

Appendix E: Study State Report of Vendors Used in the Last Ten Years

Accenture
Affiliated Computer Systems
CNSI
Deloitte
Financial Healthcare Strategies
Fox Systems
Goold Health Systems
Hewlett-Packard
Magellen
Maximus
OptumInsight
Policy Studies Institute
Public Consulting Group
RedMane Technology
Unisys/Molina

Appendix F: Medicaid Enrollment and Estimates of ACA Medicaid Newly Eligible

State	2008 Medicaid Enrollment[20]	Newly Enrolled Current Eligibles[21]
Alaska	118	50
California	10,670	2,378
District of Columbia	166	32
Georgia	1,683	774
Hawaii	224	117
Illinois	2,430	797
Indiana	1,082	374
Kansas	355	179
Kentucky	850	426
Louisiana	1,099	482
Maryland	778	301
Massachusetts	1,522	N/A
Michigan	1,968	468
Minnesota	808	260
Mississippi	737	348
Nebraska	2423	109
Nevada	260	158
New Hampshire	148	70
New Jersey	976	476
New Mexico	512	182
New York	4,937	189
North Dakota	71	33
Ohio	2,077	785
Oklahoma	752	332
Oregon	520	327
Tennessee	1,488	366
Texas	4,278	2,168
Virginia	886	500
West Virginia	402	161
Wyoming	77	38

Counts are in thousands

[20] Kaiser Family Foundation. 2011. State Health Facts total Medicaid Enrollment, 2008 web page, http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4, accessed October 18, 2011. Respondents were asked to report their own Medicaid enrollment counts or verify these published data. All but 6 states provided counts; in these cases state enrollment averaged 10% greater than the comparative estimates provided by this source.

[21] Holahan, J. and L. Blumberg. 2010. "How Would States Be Affected By Health Reform? Timely Analysis of Immediate Health Policy." Washington DC: The Urban Institute, available at http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf. Study respondents were asked to report their own estimates of newly eligible Medicaid enrollees or verify published data. Nineteen study states provided an estimate; in these cases the state estimates averaged 9% less than estimates published by this report.

Appendix G: Study State Report of Needed Functionality Not in Current Medicaid Eligibility System

- Increase functionality possible through a web application
- Employ or enhance rules engine software that decouples business rules from application code to accommodate changes efficiently and effectively
- Support automated, online, real time, application processing (using SOA)
- Support integrated eligibility system (including ABD and other Medicaid programs as well as other public assistance programs) and/or reduce errors associated with processing eligibility for more complex populations
- Support customer portal (capacity for applicants to interact with the eligibility system) and provide more self-service options including:
    - User friendly interface
    - Options for online application submission (including applications in multiple languages)
    - Acceptance of electronic and other signatures (if policy stipulates)
    - Interactive voice response (IVR)
    - Automated and robust alerts and notices, status checks, change submission
- More fully automated eligibility verification including electronic acceptance of verification documents, and electronic verification and validation of applicant data through electronic data exchanges with valid sources
- Support worker portal to improve workflow and reduce errors including:
    - Computerized case files and online case histories
    - Automated assignments of case files to workers according to their expertise and availability
    - Logic flags
    - Online policy and procedure manuals
    - Integrated document imaging
- Create easy, efficient, and accurate interfaces with other systems
- Expand data fields for program monitoring, budgeting, and evaluation, e.g., addresses, race/ethnicity, history, households, denial and churn codes
- Improve business intelligence analytics and reporting capabilities
- Support multiple security levels
- Enhance fraud prevention and enforcement tools.