# Entry into Coverage

Draft White Paper for Comment and Discussion Only

## Introduction

One of the fundamental goals of the Affordable Care Act (ACA), is to reduce the number of the uninsured. Health care reform expands insurance coverage though several different strategies: it expands Medicaid[1]; offers premium subsidies to individuals with incomes above Medicaid level[2]; imposes a requirement that individuals maintain health insurance enforced by a federal tax penalty[3]; and creates new health insurance exchanges to facilitate the purchase of insurance.[4] There are also subsidies for some small employers and penalities for employers that don't offer insurance. Together, these strategies create a "culture of insurance" where virtually everyone is expected to have health insurance through public or commercially available health insurance.

Estimates are that these combined strategies will cut the uninsured by half in Maryland.[5] But achieving these goals depends largely on the State's ability to enroll people in the new and existing coverage options available to them. Many implementation decisions are left to states. Some of these decisions will create the foundation for how Maryland will connect people to coverage and the extent to which ACA's goals of expanding insurance coverage and reducing the number of uninsured are met. In its Interim Report, the Health Care Reform Coordinating Council (HCRCC) charged the Entry into Coverage Workgroup with identifying options for Maryland to consider in its approach Entry into Coverage. This includes a broad range of issues, including:

[1] P.L. 111-148: §2001 as modified by §10201; P.L. 111-152: §1004 and §1201

[2] P.L. 111-148: §1401-15, §10105, as amended by §1001 and §1004 of P.L. 111-152

[3] P.L. 111-148: §1501(b) as amended by §10106 (b) of and by §1002 of P.L. 111-152

[4] P.L. 111-148: §1311(b)(1)(B) discusses a state option to operate two exchanges (an individual exchange and a SHOP [Small Business Health Options Program]exchange) or consolidate as one.

[5] Health Care Reform Coordinating Council (July 2010). *An Interim Report*. Retrieved from http://healthreform.maryland.gov/documents/100726appendixf.pdf

1. The structure, process and policies to determine eligibility for individuals in Medicaid, the Maryland Children's Health Program (MCHP) and income-based premium credits offered through an Exchange;

2. The point of access for individuals to enroll in health plans offered through the Exchange; and

3. The point of access for small business to enroll in health plans offered through the Exchange.

The structure and goals of the Exchange are within the purview of a separate workgroup, Exchange and Insurance Markets. There are a number of decisions about the Exchange that are fundamental to developing options for Entry into Coverage: What will be the goals of the Exchange? What functions will actually be performed by an Exchange or be left to the current private sector mechanisms for enrolling people into coverage? The Exchange and Insurance Markets Workgroup is beginning a process to examine options, but it is likely that much uncertainty will remain about how Maryland will choose to implement an Exchange. The Council will need to evaluate the Entry into Coverage options presented in this paper in the context of options being considered by the Exchange and Insurance Market Workgroup.

Federal guidance is still pending on a number of issues that are important to state implementation efforts. Federal regulations on eligibility issues are not expected until Fall 2010. While Federal policy makers are considering the possibility of providing either standards for eligibility system development or possibly components of an eligibility system to states through the use of open source software or common systems, states would still be required to complete significant information system changes as well as implement and integrate a 'common system' with existing systems. This could significantly change the focus of implementation activities for the states, but does not eliminate the significant number of implementation activities that would still be required. The data exchange standards and details of how verifications will be streamlined through connections to the IRS and other federal databases have yet to be determined. In addition, a simplified common application form across health programs is to be developed by the federal government.[6] The data elements and structure of this application will also impact information system development.

Although there are a number of uncertainties about implementation, the development of eligibility and enrollment systems takes significant lead time and s state implementation efforts must begin immediately. The Entry into Coverage Workgroup is basing its planning efforts on

[6] P.L. 111-148: §1413

the assumption that the streamlined connections to the IRS and other federal databases will be realized so that the possibility of real time eligibility determinations through a simplified process is achievable.

Workgroup Process

The Entry into Coverage Workgroup held two meetings (to date). The first meeting focused on an overview of federal reform and an overview of current enrollment systems. The second meeting invited public comments on the overall approach to Entry into Coverage. This paper summarizes the options proposed by public comments as well as options developed by Agency staff for which guidance is needed despite a lack of comment. The majority of comments focused on the process for determining income based eligibility for Medicaid, MCHP and premium credits. Several common themes emerged as goals for Maryland's Entry into Coverage implementation.

- Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;
- Eligibility determinations should be integrated and seamless (across both health and public assistance programs);
- Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HRCCC;
- There should be a "No Wrong Door" approach to applying for coverage (across both health and public assistance programs).

Background on Issues and Options

1. Structural options: Eligibility Determination for Medicaid, MCHP and Premium Subsidies for Plans Offered through Exchange

ACA requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all health programs.[7] State Exchanges have the option to contract with State Medicaid agencies to determine income based subsidies under the Exchange. Regardless of where the function is housed, Maryland has two basic structural options: Create a point of entry for consumers to health programs, managing eligibility determinations for Medicaid, CHIP and Premium Credits for Exchange products in one place; or

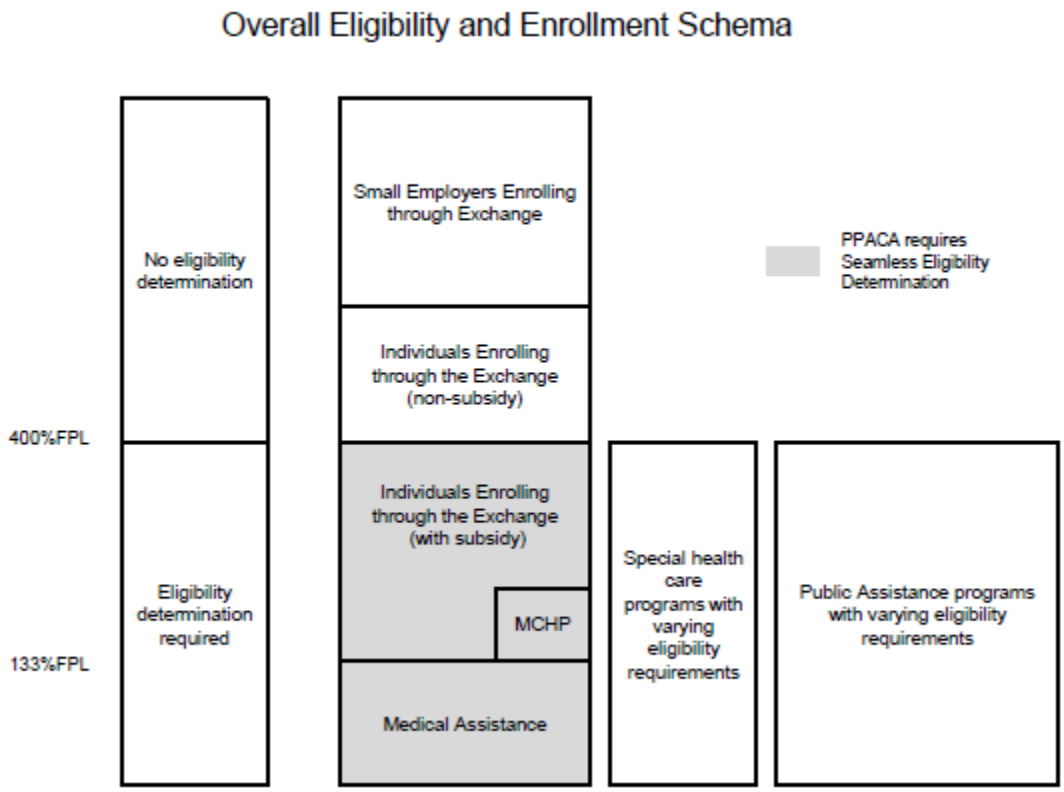
[7] P.L. 111-148: §2201

Build on the existing health and public assistance model for Medicaid and public assistance and coordinate with eligibility determination for Premium Credits through the Exchange.

Maryland's current process for determining eligibility for Medicaid has evolved over a 40 year history of changing public assistance programs and Medicaid expansions. Today, about 1,600 staff at 24 local Departments of Social Services, 23 Local Health Departments and at Maryland's Department of Health and Mental Hygiene (DHMH) review and approve applications. The Client Automated Resource and Eligibility System (CARES) supports the eligibility determination for the majority of Medicaid and MCHP enrollees, but some groups' eligibility is determined outside of the CARES system, however, the eligibility dates and status are retained in CARES. In addition, the CARES system determines eligibility for other social programs such as food, cash and energy assistance, and provides an integrated case for those individuals with eligibility in multiple programs. The Service Application and Information Link (SAIL) system is a web-based system that is available via the Internet to the public. The SAIL system allows residents to apply for benefits electronically for most Medicaid programs, food assistance, cash assistance, and energy assistance. SAIL has a real-time interface with the CARES system, providing a seamless transfer of the application data into the eligibility system without the re-entry of data. Local Departments of Social Services, Health Departments, and DHMH all use the SAIL and CARES system to support current operations.

Virtually all comments to the Entry into Coverage Workgroup called for seamless eligibility determinations through an integrated eligibility system. The challenge for Entry into Coverage implementation is how to achieve seamless enrollment to health coverage programs across the income scale as envisioned by ACA as well as coordinating eligibility determination process for related health and public assistance programs. Chart 1 illustrates the population and programs for which eligibility determinations should be coordinated.

Chart 1. Coordination of Eligibility Determinations




2. Central vs. Local Eligibility Determinations

Today, Medicaid and MCHP applications are accepted by mail, in person and through web-based applications. The applications are processed by 1,600 staff in 24 Local Departments of Social Services, 24 Local Health Departments and DHMH. There was consensus that there will continue to be a need for a local eligibility and enrollment assistance; however, the role of the traditional case worker may change as more automated systems proactively determine eligibility. This local role may be able to focus on assisting with more complicated Medicaid

eligibility cases, such as long term care and home and community-based waiver eligibility, and connecting individuals to a broader range of services and public assistance programs. The local role would need access to tools, such as a health portal or more comprehensive access to the eligibility system of record, to facilitate enrollment into Medicaid, Maryland Children's Health Program (MHCP), or Premium Credits.

A centralized administrative system could manage eligibility determinations that are based on applications that come in other than in person (mail, fax, phone, and web). This centralized system could manage data-driven eligibility determinations such as automated feeds of IRS information on prior-year income data.

These options will need to be more fully vetted when federal guidance is provided and more is known about what eligibility determinations will actually be supported by automated systems and what functions will need to be supported manually.

3. Use of Modified Adjusted Gross Income Standards (MAGI)

Today, states use a number of different standards to calculate income for the purpose of Medicaid eligibility. States use different policies to calculate income and use different income disregards in setting their eligibility thresholds. ACA requires all states to use Modified Adjusted Gross Income (MAGI) as the way to calculate income for eligibility determinations for Medicaid, MCHP and subsidies through the Exchange.[8] All states are required to apply a standard 5% disregard so that income disregards are also standardized. In some respects, this will simplify the eligibility determination process because MAGI can be calculated from Adjusted Gross Income which is a line item on an individual's tax return. ACA assumes electronic verification of income will occur through linkages with the IRS. These new requirements will change the concept of eligibility determinations with computer systems providing more ability to make real-time determinations based on electronic sources of verification.

In other respects, the change to MAGI will complicate eligibility determinations. MAGI provides household income in the prior year, but may not reflect current circumstances. Therefore, processes to gather current information will need to be established. Some stakeholders called for standardized eligibility rules and income definitions across programs. The use of MAGI will support the standardization across health programs (Exchange, Medicaid and MCHP),

[8] P.L. 111-148: §2001 as modified by §10201; P.L 111-152: §1004.

but it would be more difficult to standardize income definitions across public assistance programs and even within some Medicaid eligibility groups.[9]

Although there was little comment from stakeholders, one of the challenges of the eligibility process will be the interface with a federal tax credit process. The federal tax credit is advanceable[10], meaning that applicant can elect to receive the tax credit immediately, which will have the effect of reducing the upfront premium costs. How an individual will agree to accept the advanceable credit will affect the eligibility determination process will be important to consider.

4. Websites

ACA maximizes the role of the internet for applying and renewing coverage. HHS launched a website on October 1 that provides information on health plans available in each state and links to enrollment information on Medicaid and MCHP.[11] This website will be refined and ultimately linked to Exchanges for enrollment information. By 2014, States are also required to operate and internet website that links the Exchange, Medicaid and CHIP. This website must allow individuals to compare plans and apply for and renew coverage.[12]

Today, Maryland has web-based applications for Medicaid and MHCP and public assistance programs, but some other health programs are not currently supported by web-based application. Maryland is developing a web-based health application that combines applications for Medicaid, MHCP, the Primary Adult Care Program and local health initiatives and links to SAIL and CARES for eligibility determinations. A website that supports consumers in applying for coverage is both required by federal law and advocated for by most stakeholders.

[9] Per P.L. 111-148: §2001; certain groups are exempted from income eligibility determinations based on MAGI. They are (1) individuals who are eligible for Medicaid through another federal or state assistance program, such as foster care; (2) the elderly; (3) certain disabled individuals eligible for SSI; (4) the medically needy and (5) enrollees in a Medicare Savings Program.

[10] P.L. 111-148: §1412(a)(3).

[11] P.L. 111-148: §1103, as amended by §10102

[12] P.L. 111-148: §2201

The website will be an important way to reach consumers and could serve many functions: providing information about health programs and a means to apply, screening tools and decision tools that give consumers real time information, comparative information about health plans and choices.

Some comments expressed a concern that implementation of Entry into Coverage strategies could not rely solely on web-based strategies because many low-income and vulnerable populations do not have access to internet. Computer literacy varies tremendously and websites need to be developed in accessible formats.

5. Assistance with Eligibility

ACA calls for states to provide assistance when individuals to apply and enroll in health plans. ACA requires Exchanges to set up Navigators[13] to provide fair and impartial information regarding enrollment in health and subsidies. States are required to establish procedures for conducting outreach and providing enrollment assistance to vulnerable and underserved populations.[14]

There is broad consensus that Maryland should use a diverse network of existing community based organizations with a track record of trust in their community to assist individuals to enroll in health coverage programs. Massachusetts' experience with small grants to community based organizations was cited as a model that many wanted to pursue. This concept is thought to be particularly important for special populations that may rely on specific community based organizations for assistance. Some commented on the need for on-going stable financing to support the community assistor activity. Effective training and tools (health portals) to support community based organizations will be necessary.

Some suggested the use of out-stationed eligibility workers to facilitate enrollment. As systems are developed and it becomes clearer what the role of eligibility workers will be in a new technology enabled system, this option should be evaluated.

[13] P.L. 111-148: §1311(i)

[14] P.L. 111-148: §2201

As health coverage is expanded both through Medicaid and new products offered through the Exchange, the role of brokers and agents should be considered in assisting consumers to apply for coverage.

6. Hotline/Helpline

Many stakeholders called for a well staffed and trained hotline or helpline to be available to consumers for information on programs and how to apply. The telephone helpline/hotline could serve as an important resource for consumers in answering questions about availability of benefits. ACA also cites the telephone as one of the mechanisms for individuals to apply for coverage.[15] The hotline/helpline is an important compliment to outreach and education strategies. This hotline/helpline needs to be well staffed and trained to support the outreach and education efforts that may precede plan enrollment. Consumers should have a variety of ways to get follow-up information, including the telephone and website.

7. Strategies to Achieve No Wrong Door Goals

No Wrong Door refers to a service system that welcomes people in need and assists them to connect with desired services regardless of the agency where they try to gain access. In simple terms, it means that consumers should be able to get information and apply for programs wherever they are – at a local health department, department of social service or when they are seeking health care services or other services.

The General Assembly approved budget language requiring a study of No Wrong Door policies across a broad range of public assistance programs. ACA requires a "no wrong door" approach to eligibility determinations for income based health programs (Medicaid, MCHP, Exchange Subsidies).[16] Some changes to the eligibility determination process for health programs will make the linkage with public assistance more challenging. However, there are opportunities to use the changes to the eligibility determinations process for health to make it more seamless with related public assistance programs. These include:

a. Effective and simple screening tool for programs (health and public assistance) – A screening tool that enables consumers to input basic information and be prompted

[15] P.L. 111-148: §1311(d)(4)(B)

[16] P.L. 111-148: §1413

to ask questions that would allow a determination of eligibility for a broad range of programs is an important tool for case workers, community assistors or consumers to get the information they need about a broad range of programs and their potential eligibility. An effective screening tool could empower consumers, community assistors and case workers for a range of programs to provide information and assistance to the consumer. The SAIL system already provides this screening tool for many programs.

b. Document Management and Verifications – One of the barriers to enrollment in both health and public assistance programs is the difficultly individuals have collecting and providing documentations of income, immigration status, citizenship or other required materials. A shared document management system could ease the barrier to enrollment by allowing information to be provided once and shared among health and public assistance programs. It is also assumed that new avenues will be available to verify income for health programs through linkages with the IRS that will reduce barriers to enrollment related to income verification.

c. System to Check Status of Eligibility Determinations – Some stakeholders proposed a system that would allow consumers or community assistors access to real-time information on the status of their eligibility determination for health and public assistance programs. This system could provide information on documentation that is missing or information that is needed to complete the eligibility determination process. This concept applies to both health and public assistance programs.

d. Single Streamlined Application - ACA requires HHS to develop a single streamlined application form that can be used for applying for subsidies under the Exchange, Medicaid or MCHP.[17] States may develop their own single form as long as it meets the same standards. Some suggested the advantage of having a common application between health and public assistance programs. The federal requirements regarding the streamlined health subsidy application may make it challenging for health and public assistance to share the same application form; however, the concept that the health application could be the basis of an application and other programs would develop modules for information specific to their program is worth pursuing once more is known about what the Federal application will require.

[17] P.L. 111-148: §1413

e. Express Lane Eligibility - Prior federal law (CHIPRA) gave states the option to allow children express lane eligibility, allowing Medicaid and CHIP eligibility requirements to be satisfied based on the data from other government agencies. This means states could deem children eligible even if there are technical differences in how income is evaluated across programs. ACA preserves this opportunity, exempting express lane strategies from the new MAGI income definition.[18] Express lane strategies could allow children who are eligible for SNAP to be automatically deemed eligible for Medicaid or MCHP. Express lane strategies should be evaluated as another approach to achieving no wrong door policies.

8. Policy Issues to expedite eligibility determinations or maintain coverage

   Current federal law allows states to use presumptive eligibility for pregnant women and children. ACA extends this definition, giving states the options to allow this option for additional populations.[19] In addition, it allows hospitals to conduct presumptive eligibility.[20] This is an option to consider and some stakeholders called for this strategy to maximize coverage options. A number of stakeholders called for 12-month guarantees eligibility to reduce churning of individuals on and off of Medicaid, MCHP, or Exchange subsidy coverage.

9. Data Driven Enrollment

   ACA requires linkages with the IRS to streamline eligibility determinations for subsidy programs, Medicaid and MCHP.[21] This will streamline the application process, making determinations more real-time. More federal guidance is needed about how this will work. Consensus among stakeholders was that in additions to linkages to the IRS, other data driven strategies in which consumer are determined eligible based on existing data should be pursued.

[18] P.L. 111-148: §2001 and §2002 as modified by §10201

[19] P.L. 111-148: §2001 as modified by §10201

[20] P.L. 111-148: §2202

[21] P.L. 111-148: §1311(c)(3-6), (d)(4)

10. Empowering Consumers

Effective Entry into Coverage strategies require that consumers know how to use the system. They need clear information on the availability of assistance, the value of the benefits that coverage programs provide, and how to apply on their own or get help when they want it. The Entry into Coverage outreach efforts will need to include consumers, providers, insurers, non-profits and the general public. The importance of clear communications and the need for materials on 4th grade reading level and translations at the 4th grade level were cited. Other comments focused on the need for local input on media strategies because different strategies work in different communities.

The web resources discussed above will be an important part of reaching consumers. There are a number of additional creative strategies identified by stakeholders that hold the potential to make it easier for individuals to apply for coverage. Many of these could be low-cost and low-tech solutions to making eligibility determinations more accessible. They include:

a. Kiosks at diverse locations that provide information on health programs, applications for coverage and a way to submit the application.

b. Applications, Copiers and Drop Boxes located at public assistance offices and other locations would allow consumers to apply quickly without meeting with a case worker. This strategy was successfully employed by Delaware.

c. Fee waivers for documentation make it feasible for low-income consumers to gather necessary documentations.

d. Mobile offices in low income neighborhoods could provide information and application assistance on programs.

11. Early Expansion of Medicaid

Some stakeholders called for an early expansion in Medicaid because it would let the state phase-in what is likely to be a significant expansion. Others cautioned that restoring funding from prior reductions is important before expanding coverage further.

12. Address Broad Medicaid Eligibility Issues

Some stakeholders urged improvements in the eligibility process for the Aged, Blind and Disabled categories of Medicaid. Specifically, the delays and challenges with disability determinations and nursing home eligibility were cited.

Immediate Issues (Next 12 Months)

Maryland stakeholders have identified a number of encouraging options and strategies that could be part of an overall approach to Entry into Coverage that achieves the goals of simplifying the eligibility process; making eligibility integrated and seamless; embracing a culture of insurance; and advancing no wrong door efforts. Many of these issues are inter-related and will depend largely on federal guidance and state decisions related to the goals and functions of an Exchange.

The challenge for Maryland and all states is that many implementation activities require significant systems changes which have long lead times in planning, procurement and implementation. The Entry into Coverage Workgroup was asked to focus on the immediate issues that Maryland will need to address for successful implementation in the next 12 months. Identifying the new functions of an IT system requires a basic understanding of how a system will operate and what it will be expected to do.

Immediate Options

[To be developed]

Future Issues

[To be developed]