Coordinating Human Services Programs with Health Reform Implementation

A Toolkit for State Agencies

The Center on Budget and Policy Priorities, located in Washington, D.C., is a non-profit research and policy institute that conducts research and analysis of government policies and the programs and public policy issues that affect low and middle-income households. The Center is supported by foundations and individual contributors.

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VI. PROJECT MANAGEMENT AND COMMUNICATIONS

Eligibility Process

Background

Beginning in 2014, the number of low-income people eligible for Medicaid will expand dramatically. As Figure 1 shows, currently, adults without dependent children generally do not qualify currently for Medicaid (except in a few states that have extended coverage through waivers), and parents are eligible only if their income is very low. But starting in 2014, states will be able to expand Medicaid to cover to most individuals with incomes up to 133 percent of the poverty line.[8]

Figure 4. Most People With Incomes Up to 133% of the FPL Will Qualify for Medicaid in 2014 in States that Expand Coverage
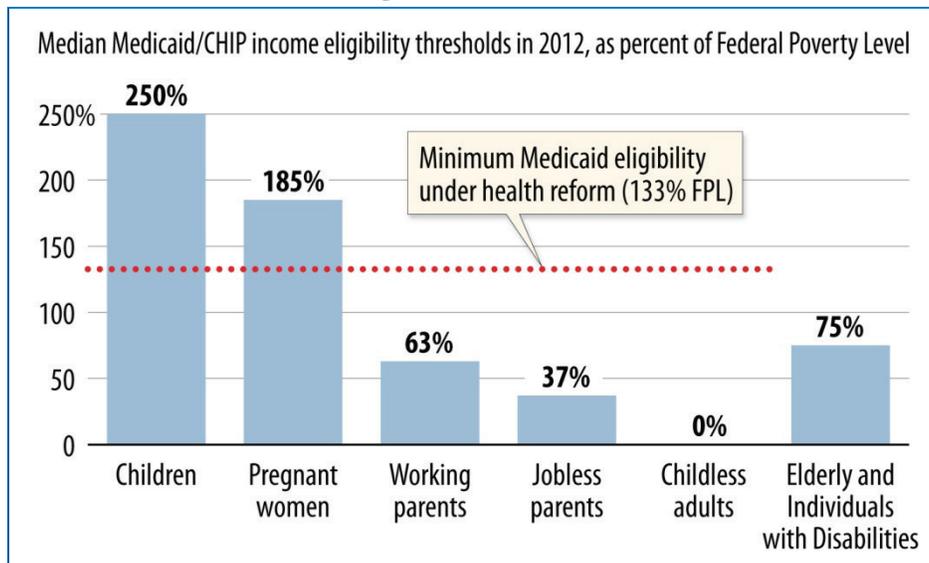
Source: Based on information gathered during a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Those with incomes above the Medicaid or Children's Health Insurance Program (CHIP) upper income limits will also have the opportunity to purchase insurance through exchanges and may be able to offset the cost of coverage if they qualify for advance premium tax credits (APTC) and cost-sharing subsidies. If all states take up the expansion, by 2021 an estimated 33 million people who would otherwise be uninsured are expected to have coverage, with Medicaid, CHIP, and the premium tax credits playing a significant role in achieving this reduction in the number of uninsured.

Regardless of a state's decision to expand Medicaid, it is expected that consumers will have access to a seamless, streamlined, "no wrong door" process for accessing and maintaining their participation in Medicaid, CHIP, and the premium tax credits. This will be no easy task, considering that families may have individuals

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[8] In determining eligibility, income equal to 5 percent of the poverty line is disregarded. Thus, the effective minimum income standard for Medicaid will be 138 percent of the poverty line.

within a household who are eligible for different health subsidies, or their circumstances may fluctuate and necessitate frequent redeterminations. New rules will require states to make changes to their eligibility processes to achieve a streamlined and simplified system across health insurance affordability programs. States must create eligibility processes that will:

- Provide a "no wrong door" experience for consumers at initial enrollment. It is unlikely that consumers will know which health insurance affordability program they qualify for when they seek services. Consumers must be able to provide their information one time and be enrolled in the appropriate program regardless of where and how they apply for coverage. This approach was taken from Massachusetts, which has one application form for multiple health coverage programs, and the Medicaid agency evaluates each form and sorts the consumer into the appropriate program, including programs run by other agencies.

- Provide beneficiaries the opportunity to report changes in their circumstances and, if necessary, ensure that individuals make smooth transitions between programs.

This will be a change in some states where enrollment procedures can seem as if consumers must know what program they want when they apply. For example, in some states that administer CHIP and Medicaid separately, if consumers apply through Medicaid but are eligible for CHIP, the state may refer them to CHIP but it does not transfer their information electronically and may even require them to complete and submit a new application. The new vision for eligibility will allow consumers to apply using one form; the state will guide consumers to their available choices based on their eligibility and transfer data electronically to other agencies as needed.

In creating the "no wrong door" for health insurance affordability programs, states can build on lessons learned from their experiences in implementing CHIP. States that that simply expanded Medicaid eligibility using CHIP funding and those that jointly administer the eligibility processes for Medicaid and CHIP have less hand-offs and file transfers to be concerned about. Those that operate separate Medicaid and CHIP eligibility structures have had to create mechanisms to appropriately "screen" and enroll children at initial intake, renewal, and during periodic redeterminations. Some states, like California, have created ways to expedite coverage during transfers between agencies. For example, the California agency that administers CHIP is able to make presumptive eligibility determinations to expedite access to benefits whenever a Medicaid-eligible child becomes known to CHIP.

How Will Health Reform Change Medicaid Eligibility Rules?

To coordinate eligibility and coverage across the different health care programs, states will make major changes in the way they determine eligibility for Medicaid and CHIP in 2014. The biggest changes involve how income and household size are defined to determine eligibility for most people in Medicaid and CHIP (as well as premium credits to purchase coverage in the exchange).

The health reform law establishes a new method — called Modified Adjusted Gross Income, or MAGI — for calculating income and household size to determine Medicaid and CHIP eligibility. The use of MAGI is necessary to standardize and simplify income eligibility across states and among Medicaid, CHIP, and the exchange premium subsidies. Detailed information about how MAGI compares to current Medicaid, and a comparison between MAGI and SNAP can be found in Appendix 1.1.

States will need to consider how these changes will affect coordination with SNAP and other benefits. There currently are differences between SNAP's income and household definitions and those used in Medicaid and CHIP, so to some extent these types of differences are not new. Also, the move to automated collection of families' information through the health exchanges and online public benefit applications, as well as the use of "rules engines" for determining eligibility, will allow states to use technology to simplify some of the more complex rules regarding income counting and unit composition.

Moving forward, states will have many choices about how to structure eligibility for each insurance affordability program. The greater the number of agencies involved in processing eligibility, the more imperative it will be to ensure that the processes and technology will ensure that consumers can access "no wrong door" to obtain health coverage.

Furthermore, many of the individuals who will be eligible for Medicaid will also be participating in other programs, such as SNAP. As states face the great workload challenge to meet the needs of those newly eligible for Medicaid, they may wish to consider how they can extend the "no wrong door" approach beyond health programs to help individuals access the full scope of human services benefits.

Although most states have a long history of using the same workforce and technology to serve individuals across benefit programs, some states have felt the urgency to prioritize their ACA planning to ensure coordination between Medicaid and the newly created health insurance exchanges. While this coordination is vital, it is also important that states pay attention to how eligibility across all benefit programs will be coordinated, to ensure that the most vulnerable individuals are connected to the full range of services for which they are eligible — and that states avoid costly duplication of effort among staff. It's also important to note that to the extent states have administered their Medicaid and/or CHIP programs together with other non-health benefit programs in the past, the changes required of Medicaid and CHIP will necessitate program changes for the non-health programs regardless of a state's decision to keep these programs integrated. For example, if a state previously had a multi-benefit program that included Medicaid, that application will have to change to meet new requirements.

Changes in the ACA require states to decide how their eligibility processes and structures will operate in 2014 and beyond. This module will help facilitate discussion to better prepare states to make decisions related to ACA implementation and its impact on overall benefit delivery across the state. Decisions states make about how to structure their eligibility processes across programs will affect every aspect of work covered in this toolkit.

Goals

This module of the toolkit will help your team:

- Take stock of its current eligibility processes.

- Identify what needs to be done to ensure that consumers can access "no wrong door" to health and human services programs in 2014.

- Identify how to serve consumers through different benefit pathways such as applying in a human services office or using an online application.

- Identify how to coordinate eligibility across programs.

- Identify the major functions, services, and/or tools that can be shared across programs.

Tools

The following tools are included in this module:

1. **Presentation:** Eligibility and coordination requirements under ACA.

2. **Exercise 1.1:** Scan of current eligibility processes for health and human services programs in the state and ways in which current processes can be improved.

3. **Exercise 1.2:** Identify what needs to be done to ensure that consumers can access a "no wrong door" in 2014.

4. **Exercise 1.3:** Identify key functions and tools that can be shared across programs.

5. **Wrap-Up and Next Steps:** Identify eligibility structure and decisions and how the structure will affect other implementation requirements including: development of applications, verifications, renewals, staffing, etc.

How to Complete this Module

First, you will want to think about whom to involve in a workgroup focused on your eligibility processes. Involving a diverse group of experts, decision makers and stakeholders will ensure that your group discussions consider all aspects of the work. You may want to consider including the following representatives:

- Medicaid, CHIP, SNAP, and other policy experts

- Representatives from your state's exchange agency

- Operational managers from field offices

- Representatives of eligibility staff and/or labor unions

- Quality assurance representatives

- Data analysts familiar with your data file

- State and/or vendor IT experts

If resources allow, you may also want to involve an outside facilitator. At the end of this section, we suggest additional background materials you may want to distribute to the group.

Each of the exercises involves holding one or more workgroup meetings. Questions have been provided in each exercise to guide your conversations, but your group should add or substitute questions as you see fit to meet your needs. As you work through discussion questions, make sure to take note of key decisions, unresolved issues that need further attention, and action steps that need to be taken to move forward with planning and implementation.

We estimate you will need approximately eight hours of workgroup meetings to complete this section. You may choose to schedule them in a series of shorter meetings or one all-day session. Feel free to modify the exercises in this section to meet your specific needs and address local conditions.

Presentation

Eligibility and coordination requirements under the ACA

To design your new system, all members of your workgroup will need to be familiar with the ACA requirements for determining eligibility. As such, we recommend starting with a presentation covering these new requirements to establish the expectations for what the eligibility system must be able to accomplish in 2014. It's likely that workgroup members who focus on Medicaid policy will be more familiar with these new requirements than others. In such cases, you may want to consider having your Medicaid or health reform experts give the presentation.

The presentation should start with a high-level vision for how eligibility determinations and enrollment in health coverage are supposed to be accomplished in 2014. PowerPoint slides (with notes) for this presentation are provided in Appendix 1.2. Feel free to modify this presentation to suit your workgroup members' current knowledge level, but at a minimum, the presentation should cover the following issues:

- States are required to develop a "no wrong door" eligibility process (application, renewal and change reporting) that minimizes the burden on consumers, and allows them to apply for all applicable insurance affordability programs using a single, streamlined application.

- The system must be seamless and allow different programs to share applicant information through secure interfaces, as well as maximize the use of technology to facilitate eligibility determinations and minimize the need for paper documentation.

- States are also required to provide processes that allow consumers to submit applications and renewals through the mail, in person, by telephone, and online (further discussed in the Applications and Renewals modules of this toolkit).

- There are many ways that states can set up their eligibility systems and processes to meet the expectations and requirements of the ACA. States can develop an integrated system in which the same entity processes eligibility across all programs. They can implement an interoperable system in which separate entities process eligibility but consumer cases are transferred seamlessly through secure interfaces. States can also implement a hybrid system in which some services, such as a rules engine, are shared between separate entities that are responsible for eligibility for different programs, and information is transferred seamlessly between the entities.

- For a limited time only, enhanced federal matching dollars, covering between 90 and 100 percent of all costs, are available to fund IT investments that improve eligibility determinations for Medicaid. Thanks to a special waiver from normal cost-allocation rules, human services programs are not required to contribute to the cost of these investments, even if such programs benefit.

Exercise *1.1*

Scan of current eligibility processes for health and human services programs

This first exercise will help your workgroup get a common understanding of how well the state's current eligibility structure and practices are working to ensure that individuals and families are connecting to all health and human services programs. All team members should become aware of the state's track record in connecting individuals to benefits, which entities are currently responsible for processing eligibility, and the current processes for making referrals and sharing information among agencies. This initial scan will help your workgroup identify current successful practices to build on as well as existing gaps that may be filled as the state contemplates changes related to ACA.

Gathering Background Information

The first step in this process is to gather background information that will be helpful to provide to workgroup members. In advance of your first workgroup session, each program area represented on your team (e.g., child care, SNAP, Medicaid, exchange, etc.) should designate one representative to participate in a data collection group. This group should allow for an appropriate amount of lead time, which will depend on your state's ability to quickly extract data from the relevant eligibility systems. We recommend having the workgroup members responsible for this assignment present their findings at the first workgroup meeting.

Using Table 1 below, identify and fill in the current income eligibility thresholds for the programs you want to integrate. Having this information will help your group understand opportunity for case overlap. If, for example, SNAP is available to those with gross income at or below 130 percent of the poverty line and Medicaid covers parents with gross incomes up to 100 percent of the poverty line, you can conclude that there is a lot of potential for case overlap, but some individuals who are eligible for SNAP will not be eligible for Medicaid.

Table 1. Current Income Eligibility Thresholds for Health and Human Services Programs

Health and Human Services Program	Applicable Income Standard (gross and/or net as applicable)
Medicaid for Children (by age group)	
Medicaid for Parents	
Medicaid for Non-Disabled, Childless Adults	
Medicaid for Aged, Blind or Disabled	
CHIP	
SNAP[9]	
TANF	
Child Care	
Other	

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[9] For states that have raised the SNAP gross income limit through broad-based categorical eligibility, keep in mind that not all households up to the higher limit will qualify for a SNAP benefit. Only those with high deductible expenses will qualify.

After identifying the potential for case overlap based on income eligibility, complete Table 2 to identify actual case overlap between SNAP and Medicaid. You may wish to include additional programs such as child care or TANF.

The table below will guide your team in identifying how many families are receiving only one benefit or both. Breaking it down by income ranges will allow your team to determine current gaps in access among those who are very likely to be eligible for both or if eligibility may be a reason for a lack of overlap.

Table 2. Program Overlap by Income

	Income (for Unit Size)				
	Under 100% FPL	**101-130% FPL**	**131-150% FPL**	**Above 150% FPL**	**Total**
Number of units (without an elderly or disabled member) that have a member (or members) that receive:					
SNAP only					
Medicaid only					
SNAP and Medicaid					
Total number of units					
Share of units (without an elderly or disabled member) with a member (or members) that receive:					
SNAP only					
Medicaid only					
SNAP and Medicaid					
Total units	100%	100%	100%	100%	100%

Note: Unit definitions and income counting rules differ for SNAP and Medicaid. These differences may present challenges. States should keep in mind that the point of this activity is to identify where the state is providing multiple benefits to the same family and/or individuals and where there may be gaps in overlap. For presentation, the state may wish to use a pie chart of the percentages in the bottom panel.

The state may want to add other programs, for example child care or TANF, by similarly exploring the SNAP and Medicaid coverage for families that participate in the other program.

After gathering information about case overlap, use Table 3 to indicate which agencies or entities currently determine eligibility for each benefit program. This will help the team identify the entities with which consumers are interacting to receive and stay enrolled in benefit programs. For example, in states with separate agencies for CHIP, child care, and SNAP, a family seeking benefits may interact with three separate agencies. Consequently, state workers from each of the three agencies may be collecting much of the same information from the family, and there may or may not be processes in place to make referrals among agencies.

Table 3. Agencies Involved in Determining Eligibility for Health and Human Services Programs

	Medicaid for Children and Families	All Other Medicaid	CHIP	SNAP	TANF	Child Care Subsidies	Other
Human Services Agency							
State Medicaid Agency							
Separate CHIP Entity							
Counties							
Other (Specify):							
Other (Specify):							

Conducting Workgroup Meetings

The second step in this exercise is to schedule one or two workgroup meetings (depending on length) to reflect on the data that has been gathered and have a discussion around current program overlap, process overlap, and areas for improvement. Below we provide a series of questions about each of these issue areas to help guide your discussions. We estimate it will take a total of approximately four hours to discuss all of the questions.

The first set of questions focuses on helping you analyze the data on case overlap among programs that you gathered in completing Table 2. You can discuss these questions as a large group or by dividing into small groups to discuss and answer questions, followed by a report-back session coupled with a full workgroup discussion. It may also be helpful to identify specific examples to support the group's answers to the questions.

1.1A   Discussion Questions on Program Caseload Overlap

Key Questions 1:	*Where is there most joint program participation? Why does this exist, (i.e. does your state deem all TANF participants to be eligible for SNAP)? Is it attributable to any specific practices? If so, what practices?*

Key Discussion Points:

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Key Questions 2:	*Where is there least amount of joint program participation? What can this be attributed to? Are there steps that can be taken to address this issue?*

Key Discussion Points:

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After your workgroup has answered the program caseload overlap questions, it will be ready to discuss how information currently flows among and within agencies. Using Table 3 as a starting place, the following questions can guide your discussion about how your state processes and IT systems currently overlap and coordinate to provide consumers with the full scope of benefits:

1.1B   Process Overlap and Coordination Discussion Questions

Key Questions 3:	*Based on information in Table 3, can a low-income family's data be in more than one eligibility IT system? If yes, how many?*
	Do any of these eligibility IT systems interface electronically to one another?
	Is there look-up capability among programs? For example, can Medicaid look at SNAP data to complete data-driven renewals?

Key Discussion Points:

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Key Questions 4: *In cases where different entities are responsible for eligibility processes for different programs, describe what has been done (if anything) to coordinate, refer, or otherwise connect individuals eligible for multiple programs. For example, if there is a separate eligibility structure for CHIP, how are referrals and transfers completed for Medicaid?*

Are individuals enrolled in SNAP automatically eligible for other programs such as LIHEAP or child care?

Has the state tried any options like Express Lane Eligibility (a children's health option to use findings from other benefit programs to verify an eligibility factor requiring any re-calculation to account for differences in methodology) to connect consumers to other programs? If so, how it has worked? What have been the outcomes and lessons learned?

Key Discussion Points:

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Key Questions 5: *In cases where the same entity is responsible for eligibility processing of a subset or all of these programs, how are consumers assessed for eligibility across all benefits?*

Are there situations where individuals are only assessed for one program (i.e. they complete an application that only provides a pathway to one program or only indicate interest in applying for one program on a multi-benefit application?

What barriers exist to connecting individuals across a full set of benefits?

What successes has the state experienced?

Key Discussion Points:

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After coming to a common understanding of how eligibility processes overlap and are coordinated, the workgroup will be ready to discuss how current processes can be improved. The discussion questions below should help to guide your conversation.

1.1C   Process Improvement Discussion Questions

Key Questions 6:   *What processes have worked best and should be retained and/or expanded?*

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Key Questions 7:   *Where are the greatest opportunities for improving current coordination and eligibility processes?*

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Key Questions 8:   *Have improvements to coordination been tried in the past? If so, what were the results?*

Key Discussion Points:
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Key Questions 9:   *What barriers have prevented past improvements in overall processes? How can these barriers be addressed?*

Key Discussion Points:
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Exercise *1.2*

Identify what needs to be done to ensure that consumers have a "no wrong door" experience when accessing health and human services programs in 2014

In Exercise 1.1, the workgroup identified strengths and weaknesses in current eligibility practices and processes that aim to connect individuals and families to health and human services programs. The challenges, gaps, and successes identified should be kept in mind as the team completes Exercise 1.2, which is focused on designing the eligibility processes to ensure that there is a "no wrong door" experience for consumers.

The ACA requires that states make changes to current Medicaid and CHIP programs to ensure coordination with the health benefits exchanges. It also provides states with new options for structuring their eligibility for Medicaid and CHIP. For example, states can now delegate all Medicaid eligibility processing to a state-based exchange (under certain conditions). States must decide which entities will process eligibility for Modified Adjusted Gross Income- (MAGI) based Medicaid, non-MAGI-based Medicaid, CHIP, Advance Premium Tax Credits (APTC) and cost sharing subsidies, as well as other state health programs. States that choose not to fully integrate benefit delivery must also decide how they will serve consumers when they present in different entry points to benefits and if there are eligibility-related services that can be shared across programs.

Conducting a Workgroup Meeting on No Wrong Door

The first step in this exercise is to convene your workgroup to set a high-level vision for how you would like to serve consumers through various pathways to benefits. The scenarios and questions below will help guide your discussion and help you make decisions about how you will serve families and how you will deploy your staff and technological resources to support your vision. This workgroup session should include representatives that are decision makers as well as individuals with a high level of expertise in policies for each program. You may also want to bring in an outside facilitator if resources allow. We estimate it will take a total of approximately two hours to go through the scenarios and answer the questions.

1.2A   No Wrong Door Scenarios

Scenario 1: Mary is a single mother with two children. She earns $21,000 a year, and receives $3,000 a year in child support. Her income is stable. When only counting her earnings, her income is 110% of poverty. When counting earnings as well as child support, her income is 126% of poverty. Mary is not on any public benefit program. She comes to the human services office seeking both health care and SNAP (if your state processes child care subsidy and TANF in the same office add these programs to all of the following scenarios and questions).

Key Questions 10: *Describe what you want Mary's experience to be in your human services office by answering the following questions: What programs can she apply for in the office? Does she encounter a greeter that finds out what Mary's needs are and directs her next steps? Is there one line for all programs/services or multiple lines that she needs to stand in depending on what programs she is interested in or what activity she is there to accomplish? Are there self-serve kiosks set up for Mary to use to fill out an online application?*

Key Discussion Points:

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Key Questions 11: *Assume that an eligibility worker has been able to verify all eligibility factors to complete a Medicaid determination for Mary but still needs more information to verify Mary's information to complete the SNAP income verification requirement, what happens next? Will Medicaid be approved immediately while SNAP awaits the additional verification? How will this work? Is the application split? (Information about the ACA verification requirements for Medicaid can be found in the toolkit section on verification).*

Key Discussion Points:

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Key Questions 12: *Assume Mary's salary cannot be electronically verified and she does not have a copy of her paystub, so the eligibility worker cannot determine her eligible for Medicaid or SNAP. Will Mary have the option to follow-up and provide the documentation online (e.g., by creating an online account and scanning documents)? Or by mail? Will the worker call Mary's employer to verify income? Will the process of following-up with Mary for the additional documentation be different for Medicaid and SNAP? How do timeliness standards for each program affect your state's decision on how to proceed?*

Key Discussion Points:

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Scenario 2: Assume the same characteristics of the family in scenario one, only now Mary and her children are already enrolled in SNAP and are now seeking to only enroll in health coverage.

Key Questions 13:	*Does anything change about how Mary is served in the human services office? Will she be assisted by an intake worker? Will she be directed to complete a self-serve online application at a kiosk? Will she be given a paper application to complete or asked to call the health call center? (Information about the ACA application requirements for Medicaid can be found in the toolkit section on applications).*

Key Discussion Points:

Key Questions 14:	*If Mary can be assisted by an intake worker, can the worker use relevant information that was verified for SNAP, such as income, as verification for Medicaid?*

Key Discussion Points:

Key Questions 15:	*If Mary is directed to apply using the self-serve online application at a kiosk, will there be anyone available to assist her if she has questions? Will the online application have access to "real-time" electronic verifications? Will the online application have access to information from the SNAP case file? If the application cannot verify all eligibility factors, but Mary has brought paper documentation, will she be able to upload the information into the application using a scanner at the kiosk or will she be able to turn in the documentation to staff at the human services office?*

Key Discussion Points:

Key Questions 16:	*If Mary is directed to apply for health coverage using a paper application, will she be given the opportunity to complete and turn in the application at the human services office? Will Mary be able to get assistance at the human services office if she has any questions or requires help? Will Mary be instructed to mail the application into a health coverage processing center or told to apply by calling the health coverage call center?*

Key Discussion Points:

Scenario 3: Assume the same characteristics of the family in scenario one. Mary and her children are not enrolled in any public benefit program and Mary is seeking to enroll in SNAP and health coverage. She applies using a self-serve online application.

Key Questions 17:   *Will Mary be able to apply for both SNAP and Medicaid using one online application?*

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Key Questions 18:   *If Mary can only apply for health using an online application, will she be notified about the availability of other benefit programs like SNAP? Will she be provided an opportunity to consent to send relevant information to SNAP to start the application process? Will she be provided a link to get an application for SNAP? Who will process eligibility for the Medicaid application?*

Key Discussion Points:

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Key Questions 19:   *If Mary can apply online using an application that is only for SNAP, will she be notified about the availability of Medicaid? Will she be provided an opportunity to consent to send relevant information to Medicaid to start the application process? Will she be provided a link to the health application? Who will process eligibility for the SNAP application?*

Key Discussion Points:

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Key Questions 20:   *If Mary uses an online application to apply for Medicaid and SNAP at the same time, who will be responsible for processing eligibility?*

Key Discussion Points:

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Key Questions 21:	*If Mary uses an online application to apply for Medicaid and SNAP and all eligibility factors are verified electronically for Medicaid, will there be any staff involvement in processing Mary's Medicaid eligibility determination? If so, who will be assigned the processing task? Who will process the SNAP application?*

Key Discussion Points:

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Key Questions 22:	*If Mary applies online using the Exchange portal, will the exchange complete the determination for Medicaid or will it only conduct an assessment? If an assessment is completed, who will determine eligibility for Medicaid? How does the transfer of information occur? What happens once Medicaid receives the case? What additional steps will be needed to approve the case (will there be additional eligibility factors that need to be verified)?*

Key Discussion Points:

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Conducting a Workgroup Meeting on Program Coordination

If your state decides to have more than one entity process eligibility for health and human services programs, you will want to schedule another workgroup meeting of approximately two hours to discuss coordination issues. The discussion questions below will help frame your conversation. Because this discussion is largely focused on operational issues, you may want to adjust your workgroup membership to make sure you have appropriate representation from the work units that will be affected. If you have the facilitation resources, you might also want to develop a process map that describes how some of these hand-offs will occur.

1.2B   Program Coordination Discussion Questions

Key Questions 23:	*Which entities will process and/or maintain eligibility for each program (non-MAGI-based Medicaid, MAGI-based Medicaid, CHIP, APTC, SNAP, Child Care, TANF, etc.)?*

Key Discussion Points:

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Key Questions 24: *How will each entity complete a screening to identify those eligible for a program other than the one they are determining? Will they use all of the same policies and verifications?*

Key Discussion Points:

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Key Questions 25: *What information will be transferred between agencies?*

Key Discussion Points:

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Key Questions 26: *How will files be transferred between agencies?*

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Key Questions 27: *What timeliness standards and other accountability measures will be put in place for the transfer of files and the ultimate determination of eligibility?*

Key Discussion Points:

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Key Questions 28: *How will disputes be resolved when entities disagree about determinations?*

Key Discussion Points:

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Key Questions 29:   *Will all state entities operate the same IT eligibility system? If not, how will cases be transferred and what IT functionality will be needed to make data transfers occur securely and seamlessly?*

Key Discussion Points:

Exercise *1.3*

Identify key functions and tools that can be shared across programs

All health and human services programs must complete certain key functions to serve clients. They must have mechanisms in place to accept and process applications and changes reported by clients, and to initiate and process renewals. States use a variety of tools to accomplish these functions, including call centers, centralized processing centers, online portals and customer service centers that allow for in-person help. Regardless of how your state allocates eligibility processing responsibility to different entities, opportunities to share these tools may exist.

Gathering Background Information

The first step in Exercise 1.3 is to gather some background information for a subsequent workgroup discussion on which benefit programs have, need, or could benefit from the various tools available to process applications, changes in circumstances, and renewals. Use the table below to determine where different benefit programs have overlapping uses or needs for call centers, online portals, centralized processing centers, in-person customer service, etc.

Table 4. Program Use of Tools and Services for Various Eligibility Functions

	Call Centers	Online Consumer Facing Portals	Centralized Processing Center	In-Person Customer Services	Other (mail, IVR, online chat, , etc.)
	List of programs that have, need, or want this tool				
Accept and process applications (including verification)					
Accept and process changes					
Send/process renewals					

Conducting Workgroup Meetings

After completing the inventory of the tools that benefit programs currently have and/or need, the second step is to have a workgroup discussion about how to make these services available, and which of these services can be shared among programs (each of these functions is discussed in further detail in other modules of this toolkit; this module will help states make high-level decisions about these processes to inform later activities). You should be able to complete this in one workgroup meeting of no more than two hours. Below are discussion questions you may use to facilitate a workgroup conversation about sharing services.

1.3   Shared Services Discussion Questions

Key Questions 30:   *Can the human services office fulfill the in-person access requirement for Medicaid programs and CHIP? What about for Exchange programs?*

What would be needed in terms of staffing? Training? Technology?

**Key Discussion
Points:**

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Key Questions 31:   *How can the online application be designed to be a pathway to all human services rather than just health subsidies?*

If the state is using separate staff and eligibility systems, what needs to be done to program the application to send only necessary information to each entity?

Will consumers be given the option to select all programs they are interested in upfront in the application, at the end, or a combination of both?

**Key Discussion
Points:**

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Key Questions 32:   *Will the state have multiple call centers for each individual program? Which programs can share call centers? What are the main duties of the call centers?*

What IT systems will be needed to support call centers? How will calls be screened and triaged? Will you take a first-contact resolution approach?

What staffing, training, and technology needs do you have to consider?

**Key Discussion
Points:**

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Key Questions 33:　　*Who will process applications, changes, and renewals completed by mail?*

What staffing, training, and technology needs do you have to consider?

Key Discussion Points:

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Key Questions 34:　　*How will IT work together to ensure that the systems can work together and seamlessly share information?*

Will the state share a rules engine or other key IT components and/or functionality such as data imaging or a data warehouse?

Key Discussion Points:

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Key Questions 35:　　*Will the state operate one or multiple IT eligibility systems?*

If multiple, what information will be shared and transferred among systems? Which systems will be sharing information?

What data sharing agreements need to be in place? Who will negotiate those agreements?

Key Discussion Points:

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Key Questions 36:   *What is the timeframe and staging for developing/updating systems in preparation for the Medicaid expansion?*

Key Discussion Points:

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Key Questions 37:   *If systems will be integrated across benefit programs, what is the timeframe for full implementation across programs?*

If implementation will be phased in, what are the plans for processing eligibility within phases?

How will the phased approach affect staff? What can be done to minimize the burden on staff while ensuring that consumers still have access to the full scope of benefits?

Will the timeframe allow for full utilization of the 90/10 match and cost allocation waiver?

Key Discussion Points:

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Wrap-Up and Next Steps

Determine how eligibility will work in your state

By now your workgroup should have a common understanding of current processes, including what works well and areas for improvement, determined who will handle eligibility for health insurance programs and human services, identified next steps that need to be taken if eligibility will be processed by separate entities, and identified key functions and tools that can be shared across programs. As a final step, you may want to wrap up your last workgroup meeting by identifying the following: decisions made on the various issues discussed in the workgroups; areas where decisions still need to be made and what additional information is needed to make a decision; next steps for making additional decisions or implementing decisions already made; and the timeframe for moving the planning process along. These questions will help your workgroup finalize your eligibility processes and decisions and determine how they will affect other implementation requirements, including the development of applications, verifications, renewals, staffing, and other components of your model.

1.4　Wrap-Up Discussion Questions

Key Questions 38:	*What are your state's goals for ensuring that individuals have access to the full scope of benefits for which they are eligible?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 39: *What are your state's goals for reducing the burden on individuals to enroll in the full scope of benefits?*

Key Decisions:
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Decisions Pending:
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Next Steps:
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Key Questions 40: *What coordination practices should be retained, enhanced, and/or built on (based on discussion in Exercise 1.1)?*

Key Decisions:
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Decisions Pending:
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Next Steps:
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Key Questions 41:   *What processes will you put in place to ensure access to "no wrong door" for health and human services programs (based on discussion in Exercise 1.2)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 42:   *Which entities will make eligibility determinations for each health and human services program? For states that will not be fully integrated, which programs will be separate and how will the referral processes and data transfers work (based on discussion in Exercise 1.2)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 43:　　*What services will be shared by different programs (based on discussion in Exercise 1.3)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 44:　　*What are your high-level plans for replacing or upgrading current eligibility system(s) to meet the new Medicaid requirements (based on discussion in Exercise 1.3)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 45:   *What changes will be made to other human services eligibility systems to integrate with or link to the new/upgraded Medicaid system (based on discussion in Exercise 1.3)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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Key Questions 46:   *If systems will be phased in to integrate multiple programs, what are your plans for processing eligibility for individuals eligible for multiple benefits in the interim (based on discussion in Exercise 1.3)?*

Key Decisions:

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Decisions Pending:

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Next Steps:

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