IMPROVING THE DELIVERY OF KEY WORK SUPPORTS:

Policy & Practice Opportunities at A Critical Moment

By Dorothy Rosenbaum and Stacy Dean

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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, individual contributors, and publications sales.

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CHAPTER 1: POLICY OPTIONS

Why are policy changes important?

In recent years, in an effort to increase access and/or streamline administrative processes, most states have successfully simplified enrollment policies within some of their individual benefit programs. However, very few states have systematically tried to coordinate policies across the work support programs they administer.

For example, many states have expanded and simplified eligibility for children's health coverage under Medicaid and CHIP as well as moved to short, mail-in, health-only applications in an effort to enroll more children in these programs. While such in-program simplifications may make it easier for families to obtain an individual benefit, they do not ensure that families will receive the full array of benefits that are available to meet their needs (such as health coverage for parents, child care, or assistance with food, energy, or cash income support). Further, without assessing the full landscape across benefit programs, states may have policies on the books that actually work at cross purposes. Following are several examples of how uncoordinated policies can be problematic both for families needing support and for the eligibility workers trying to assist them.

- **Uncoordinated policies mean extra paperwork and confusion.** When renewal periods, for example, are not coordinated across programs, families must reapply separately, and often in different months, to maintain eligibility. It can be confusing to keep track of the various deadlines. Further, states must process multiple renewal applications.

- **Inconsistent policies can undermine goals.** Questioning the long-term wisdom of requiring low-income households to liquidate their modest savings in order to obtain a needed benefit, some states have eliminated asset tests in individual programs. However, it is not uncommon for a state to have eliminated the test in its children's Medicaid category and child care yet retained it in SNAP and for the family Medicaid category. Because so many families in need receive benefits across these programs, such inconsistency may render moot the paperwork improvement made in an individual program. If a family applies for children's Medicaid and SNAP and the latter has an asset test, the less restrictive test will ensure the children get health coverage if the family has modest assets. But, from the perspectives of the eligibility worker and the family, the fact that Medicaid may have eliminated the asset test is of no help in reducing documentation and paperwork requirements. The worker must ask about assets and the family may need to provide verification.

- **Conflicting rules can trigger additional work and confuse families.** Almost every state has moved to "simplified reporting" in SNAP (under which families report only major changes in income), yet few have done so in Medicaid, even though states have the flexibility under federal rules to coordinate reporting rules. As a result, if a family reports a small income change to Medicaid, the worker may then be required to verify and act on the change for SNAP, even though the change did not actually require a report to SNAP and did not affect Medicaid eligibility.

- **Varied requirements are confusing at the local level and often increase errors.** When state policy officials issue conflicting guidance to localities on the same issue for Medicaid and SNAP, families and eligibility workers are left to sort out the differences, and the likelihood of errors and missing paperwork increases. For example, if a state is working to simplify the eligibility process in both programs, but in SNAP the policy guidance indicates that families with earnings must still have an in-person meeting, while Medicaid policy officials have decided that the state should look to administrative data first for income verification, then eligibility workers at the local level will need to reconcile how to process income verification for a family that applies for both benefits and make sure they calculate monthly income for the family correctly for each program.

While a single divergent policy may not, by itself, create enormous inefficiencies, the cumulative impact of conflicting policies — across all of the benefit programs, the millions of families who use them, and the staff who administer them — creates a substantial level of unnecessary bureaucracy and inefficiency. Well-thought-out policy changes can enable important procedural modifications (detailed in the next chapter) that can make state operations substantially more efficient.

Why is it challenging to change policy?

States seeking to coordinate policies across work support programs may face a number of challenges. For example:

- **Programs and policymakers tend to operate in silos.** At both the federal and state levels, within agencies and/or in legislative bodies, policy- and decision-makers do not always have open lines of communication, may not consider program alignment to be a high priority, or may feel strongly that different requirements serve the unique purposes of an individual program and should not, or cannot, be modified. In addition, federal policymakers rarely coordinate with each other and are not always transparent about what options are available to states.

- **Opportunities for change may only be available in one program.** Whether at the federal or state level, policymakers may only be able to move program improvements in one area. For example, when a piece of legislation pertaining to one program is under consideration, governing committees for another program may not be interested in pursuing legislation. Given that programs do operate in silos, seizing available opportunities to move program improvements in a single program often makes sense, but this can frustrate coordination efforts. And, it can mean that when change does come in a second program, it is implemented somewhat differently than the first.

- **Budgets may be tight.** While coordination of efforts can reap substantial administrative savings, it also may increase enrollment, which necessarily increases costs. For programs with capped federal funding, like child care, increased enrollment costs will be fully borne by the state. In Medicaid, the state will need to share in the costs. In addition, some policy improvements that can reap long-term administrative savings may require an investment of resources up front.

- **Policy changes require a management investment.** To effectively implement new policies, states will need to retrain front-line staff and supervisors, as well as monitor implementation and ongoing operations. This can be labor-intensive or even costly under some circumstances.

- **Antiquated systems may not easily accommodate a change.** States frequently operate with computer systems that are decades old and difficult to reprogram. While policy staff may want to make a simplification, it might not be possible within the existing eligibility system, or the time and resources needed may delay making the change.

- **Unintended consequences can occur.** Without careful attention to detail, efforts to coordinate program rules could end up increasing, rather than easing, barriers to participation. For example, while most states allow mail-in or online applications for health coverage programs, under SNAP rules applicants must be interviewed (in person or by telephone). If a state decided to conform all of its Medicaid rules to its SNAP rules, many families would face additional requirements.

For these many reasons, although policy coordination is an important overarching goal, it should not be pursued at any cost. In some instances retaining variations in policy may be necessary or desirable.[18]

Policy Options States Can Pursue

The combination of significant flexibility in federal rules and states' full discretion to design and implement state-run programs gives states a great deal of room to make policy changes that minimize conflicts and redundancies for families trying to obtain multiple work supports. Following is a list of policy options that states may wish to consider to reduce the time- and labor-intensiveness of eligibility processes. In most cases, these policies can be implemented without federal waivers and face no other major barrier beyond the need for a state plan amendment or policy manual change. Of course, some states will need to navigate processes such as formal rulemaking procedures; a few states have written basic program rules into state statute, meaning the state legislature must enact basic policy changes.

Before adopting a change statewide, some states may prefer to pilot simplified policies with a subset of the population, such as more stable families, those in a limited geographic area, or those seeking renewal rather than initial application.

This chapter focuses on *policy* options — the kinds of items that might be found in the state's policy manual. Chapter 2 focuses on the *processes and procedures* needed to get the work done. In

[18] Some differences in program rules cannot easily be reconciled because of fundamental differences in program purposes. For example, the unit for SNAP eligibility is all people who live together and purchase and prepare food together, whereas for health coverage the unit is people who are legally responsible for one another, like parents and their children. Similarly, Medicaid has requirements for third-party liability and medical support from non-custodial parents that generally are not present in other programs. However, it still is possible for states to simplify their policies within these constraints, and in some instances more sophisticated technology can help states address differences. Or, in some cases, eligibility options can permit states to grant eligibility for one program based on determinations made by another program, notwithstanding the differences in technical program rules.

some ways this is an artificial distinction because policy and procedure are intertwined. For example, while it is a policy decision that applicants for one program be screened for eligibility in other programs, a state implements that policy through the application procedures it selects. Given the close connection between policy and procedure, these two chapters should be read together.

The policy options reviewed in this section fall into four categories:

- Policies that expand and/or simplify eligibility
- Policies that provide seamless enrollment across programs
- Policies that expedite the application process for families and eligibility workers
- Policies that increase retention and simplify renewal.

Policies That Expand and/or Simplify Eligibility

In both SNAP and Medicaid, federal funds are available for states to expand eligibility beyond federally identified thresholds. Doing so means giving needed support to a larger number of working families and families with unemployed workers. The policy options through which a state can expand eligibility also may help it coordinate eligibility and enrollment processes across programs, creating administrative efficiencies.

The options discussed here include:

- Eliminating (or simplifying) asset tests across programs
- Raising income limits.

Eliminating (or Simplifying) Asset Tests Across Programs

Policymakers in many states have questioned the long-term wisdom of requiring low-income households to liquidate their modest savings in order to obtain health insurance, food assistance, or other work supports. While only a very small number of applicant households have assets that end up disqualifying them, a substantial amount of agency time has to be spent investigating and verifying asset information across all applicants and training staff on asset rules. The result is higher administrative costs for states, greater opportunities for error, and eligible families failing to complete the application process. As a result, over the last decade, many states have eliminated asset limits (or significantly simplified asset verification) within individual work support programs.

However, to realize the vision of this policy simplification, the change must occur across all work support programs, and eligibility workers must be trained to stop asking for verification of assets when families apply. As of January 2011, almost all states had eliminated the asset test in their children's health insurance programs, but fewer than half had done so in their family health coverage programs (for parents' eligibility.) While almost all states forgo an asset test for child care assistance, most states still require it for TANF cash assistance and many do for SNAP.

In January 2014, when the health reform law's Medicaid expansion goes into effect, states will no longer consider assets in determining eligibility for health coverage programs for most Medicaid beneficiaries, including low-income children, parents, and other adults.[19] Of course, states can eliminate this test prior to 2014. In addition, states that retain an asset test in SNAP or child care should consider eliminating it so that when the 2014 change occurs, this simplification will be consistently applied across all work support programs.

Table 2

Number of States that Have Eliminated the Asset Test	
Child Health (Medicaid/CHIP)	48
Child Care	49
SNAP	37
Family Health (parents)	24
TANF	5

Raising Income Limits

Although Medicaid and SNAP have federal rules covering income eligibility, to varying degrees states have flexibility to set higher limits. Such changes can make more families eligible for benefits and in some cases can improve alignment across programs. This section discusses two state options related to income limits.

- **Eliminating tiered eligibility thresholds for children in health care programs.** Current federal Medicaid law establishes minimum eligibility standards for children based on age. All otherwise-eligible children under 6 years old with family incomes below 133 percent of poverty and those ages 6 to 18 with family incomes below the poverty line qualify for Medicaid, while those with higher incomes qualify for CHIP. Such "tiered" income thresholds mean that within a single family, different children may be covered by different programs, have to see different doctors, and go through entirely separate application and renewal processes to obtain and maintain their health coverage. This can result in confusion among families, duplicative work for states, and ultimately lower participation levels among eligible families.

  To minimize this problem, some states have opted to use the authority to use "less restrictive methodologies" for Medicaid eligibility[20] or CHIP funds to expand coverage to all eligible children to a specific income level, regardless of age. This policy change can go a long way towards streamlining access and enrollment. And, any use of CHIP funds for this purpose would only need to be temporary; in 2014, all otherwise-eligible children and adults under 65 with family incomes below 133 percent of poverty will be eligible for Medicaid.[21]

- **Increasing gross income limits.** States have flexibility to lift income limits in Medicaid and SNAP to allow more families to qualify. In Medicaid, states can use waivers or less restrictive methodologies to increase eligibility limits for parents, and since the enactment of health reform, have gained the ability to cover childless adults up to any desired income level. In SNAP, states can raise the gross income limit to as much as 200 percent of poverty by using

[19] Asset tests will remain for Medicaid coverage for certain populations, such as the elderly and people with disabilities.

[20] "Less restrictive methodologies" is authority under section 1902(r)(2) of the Social Security Act.

[21] Under health reform income disregards and deductions will no longer be allowed, other than a flat income disregard of 5 percent, so the effective eligibility limit will be 138 percent of poverty (133 percent + 5 percent).

"expanded categorical eligibility."[22] A higher SNAP gross income limit is particularly beneficial for working families that have high child care or shelter expenses. For example, a single parent with one child who works 40 hours a week at $10 an hour would not qualify for SNAP in a state with a gross income limit of 130 percent of poverty, because her income would put her at about 141 percent of the poverty level. However, if the state raised the gross income limit, she could qualify for $100 or more a month in SNAP benefits once her shelter and child care expenses are deducted.

Wisconsin, for example, has expanded Medicaid eligibility for adults up to 200 percent of poverty. With these higher income limits the state could, without ending eligibility for individuals, eliminate most Medicaid income deductions and disregards, so policy and training on income can be simpler. Wisconsin also implemented expanded categorical eligibility for SNAP with a gross income limit of 200 percent of poverty.

In 2014, when the health reform law takes effect, Medicaid and CHIP income limit rules will change and all states will use a new tax definition of income, Modified Adjusted Gross Income (MAGI), for Medicaid and CHIP eligibility (see box 3), but states still will have the option to set higher income limits for Medicaid.

Policies That Provide Seamless Enrollment Across Programs

Families that are eligible for one work support program are generally, based on their income, eligible for many other programs as well. As a result, requiring multiple application processes is often unnecessary. Following are two ways states can take advantage of the natural overlap in families' eligibility to automatically enroll them in multiple work supports:

- Allow "passive" or "Express Lane" applications
- Use "Presumptive Eligibility" determinations.

Allowing "Passive" or "Express Lane" Applications

Families seeking work supports face a confusing jumble of application options. Most states have a joint application that includes TANF, SNAP, Medicaid, and sometimes CHIP and/or child care. At the same time, almost every state has created a separate, short application for children's health insurance, and many also have SNAP-only or child care-only applications. With all of these application options, families often do not know which programs they qualify for, which applications to use, or how to get screened for all available programs. In addition, they must go through multiple enrollment processes to receive a full package of supports.

States can address this problem — and save time for everyone — by allowing eligibility determination for one program to automatically confirm eligibility in other programs and enroll the

[22] See: USDA, *Improving Access to SNAP through Broad-based Categorical Eligibility,* September 30, 2009, http://www.fns.usda.gov/snap/rules/Memo/2009/093009.pdf. Not all households up to the higher limit will qualify for SNAP benefits, however, because they still are subject to the benefit calculation formula, which will result in a zero benefit for many households at higher income levels.

Box 3
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 when the health reform law's coverage expansions go into effect in 2014. The new rules will align with the income tax-based rules for premium credits in the health exchanges. The biggest changes involve how income and household size are defined to determine eligibility for Medicaid and CHIP (as well as the exchange premium credits).

- **Income:** The health reform law establishes a new definition of income — called Modified Adjusted Gross Income, or MAGI — that will be used in determining eligibility for premium credits, Medicaid, and CHIP. MAGI is Adjusted Gross Income as determined under the federal income tax, plus any foreign income or tax-exempt interest that a taxpayer receives. (Assets will not be considered in determining eligibility for most beneficiaries.)
- **Unit members:** In determining income eligibility for premium credits, an individual's family size will be based on the size of the individual's tax filing unit. The unit income thus will be the MAGI of the taxpayer, the spouse (if any), and any child or other person who is claimed as a tax dependent (including the income of any person who must report his or her income on a separate return but is still claimed as a dependent by the taxpayer).

In general, Medicaid will cover low-income adults and children with incomes up to 138 percent of the poverty line.[1] But the change to MAGI will mean that the calculation is somewhat different from the way Medicaid (and CHIP) calculate income today:

- MAGI will be closer to a measure of gross income. The income deductions and disregards that many states currently use will no longer be applied.
- Many items now included in income for the purposes of determining Medicaid eligibility are excluded from taxable income for purposes of the federal income tax — and hence will not count when using MAGI. These include child support, most Social Security income and other income from public benefit programs, and pre-tax contributions for purposes such as child care, retirement savings, and the employee's share of employer-sponsored health insurance premiums paid through a cafeteria plan.
- Basing family size and household income on the tax filing unit will result in some differences in whose income is counted in determining eligibility. For example, the income of step-parents or grandparents is usually not counted currently when determining eligibility of a child, but under MAGI, the treatment will depend on whether the adult claims the child as a dependent on his or her tax return.

The use of MAGI is necessary to standardize and simplify income eligibility across states and among Medicaid, CHIP, and the exchange premium subsidies. Federal guidance on some of the more technical aspects of the change to MAGI is anticipated.

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 family's 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.

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[1]The health reform law does *not* change Medicaid eligibility rules for beneficiaries who are in certain eligibility categories, such as those based on disability or on being age 65 or older.

family in those other programs. The federal child nutrition program, for example, requires that all children who are SNAP participants be automatically enrolled in, or "directly certified," for free school meals, with no additional paperwork. In another example, **New Jersey** is one of many states that deem SNAP recipients automatically eligible for home energy assistance (LIHEAP). As a result, the local LIHEAP agency does not have to conduct additional eligibility screens for most families that receive SNAP.

To encourage this kind of streamlining, the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) created an option called Express Lane Eligibility (ELE), which allows Medicaid and CHIP agencies to use a finding from another state agency (such as family income) to determine whether a child satisfies one or more eligibility criteria for Medicaid or CHIP. ELE allows states to use the other program's finding without having to apply Medicaid or CHIP methodologies; for example, if a state used a SNAP income finding to determine a family's Medicaid eligibility, it would not have to factor in differences in what type of income (or which family members' income) is counted in order to use the finding for Medicaid.

States can use ELE to initiate new applications or to facilitate renewal. Several states, including **Louisiana,** have found ways to use this option to simplify the enrollment process for eligible children. In early 2010, Louisiana (where separate agencies administer Medicaid and SNAP) used an electronic file of all children receiving SNAP benefits to enroll more than 10,000 previously uninsured children in health coverage.

Even in states that co-administer eligibility for Medicaid and SNAP, ELE can play a role in covering more children. For example, **Oregon** has begun cross-checking enrollees to identify children that are in SNAP households but are not enrolled in Medicaid or CHIP. One month after SNAP enrollment, SNAP households with at least one child that is not enrolled in Medicaid or CHIP are sent letters notifying them that their child(ren) might be eligible to be "express-laned" into health coverage. If the uninsured child or children do not become enrolled in health coverage after that initial mailing, they are sent another letter after they have completed their six-month report for SNAP. Parents can confirm their interest in enrolling their children by completing the short application included with their letter or by calling their eligibility worker.

This kind of approach may be particularly helpful beginning in 2014, when health reform goes into effect. Many adults who will be newly eligible for Medicaid will already be participating in SNAP. States could seamlessly enroll these individuals in Medicaid on January 1, 2014, and continue to do so on an ongoing basis. Such automatic enrollment could prevent significant duplicative work for states and families.

Using "Presumptive Eligibility" Determinations in Medicaid and CHIP

Under federal law, states can enlist "qualified entities" outside the Medicaid or CHIP agency (e.g., health providers, schools, some child care providers, and WIC offices) to help them improve access to health coverage benefits for children and pregnant women.[23] This process is called "presumptive

[23] The health care reform law expanded presumptive eligibility to 1) allow PE for parents and other newly eligible individuals and 2) require states to allow hospitals that are Medicaid providers to be a qualified entity for purposes of determining PE.

eligibility" (PE).[24] Through PE, if a child is eligible for Medicaid or CHIP based on the family's reported income and other circumstances, he or she can be immediately enrolled and have full access to coverage while completing the regular eligibility process.

Presumptive eligibility is an efficient way to connect children and pregnant women to coverage when they present as part of a household seeking other work supports. In **California,** for example, where Medicaid and CHIP eligibility are determined by separate agencies, if a Medicaid-eligible child applies for CHIP instead, the CHIP program presumptively finds the child eligible for Medicaid.

States that have adopted the presumptive eligibility option often enlist health providers such as hospitals and Federally Qualified Health Centers to complete the PE determinations. These entities also can be trained to provide information and application assistance more broadly so that they can connect presumptively eligible individuals to other work support programs, and help families make the transition from short term health coverage to on-going eligibility.

Short of using information from one program to *directly* enroll families in another program, states can take a variety of other steps. For example, they can use check-boxes on an application to ask if a family wishes to receive information about applying for other benefits. Or, they can conduct targeted outreach to families that are enrolled in one program but not in others for which they appear to be eligible. Even more effective are strategies that use data from a different public benefit program (or other authoritative sources of information) to "pre-populate" an application form that can be filed without waiting for families to respond to outreach efforts. These and other procedural strategies are discussed in the next chapter.

Policies that Expedite the Application Process for Families and State Workers

Among the most cumbersome aspects of many current benefit eligibility processes are the requirements for families to appear in person for multiple interviews and to produce a complicated series of documents to verify eligibility.

There are a number of high-impact policy changes that states can make to overcome these barriers. In so doing, they can expedite processing, increase efficiency for state workers, and decrease burdens on families. Further, these efforts will increase the likelihood that families will receive the full package of work supports for which they qualify. This section reviews strategies in the following areas:

- Getting rid of (or minimizing) in-person requirements
- Decreasing, streamlining, and automating documentation requirements
- Sharing verifications across programs
- Using all available data sources.

[24] In child care, the term "presumptive eligibility" is used when a state allows subsidies to begin immediately for some families — before all documentation is provided or verified — if certain criteria are met that reduce the likelihood of error. The goal of presumptive eligibility in child care is to help families get child care in place before they have the first paystub from a new job.

Getting Rid of (or Minimizing) In-Person Requirements

For working families, people living in rural areas, and those with limited access to transportation, in-person appearances at the welfare office can be particularly challenging to manage, and can result in an unnecessary loss of benefits. States can address this problem through two simple policy changes:

- **Eliminate requirements that families appear in-person at a local welfare office to apply for or retain work support benefits.** For health insurance and child care programs in particular, states have full flexibility to use mail, telephone, or online communication for the application and renewal processes. For SNAP, states must interview a family member at initial application and once a year thereafter, but the interview can occur by telephone. If a SNAP in-person interview presents a hardship for the family, then the state must instead conduct a telephone interview. USDA has found that states that have used telephone interviews widely in lieu of face-to-face interviews have not experienced higher error rates as a result.

  As states consider changing their interview policies, it will be important to ensure as much consistency across programs as possible and to accommodate instances in which eliminating a face-to-face interview is not feasible or desired. For example, in TANF, a state may feel that periodic face-to-face interaction for purposes of work support assessment and monitoring is necessary. However, the initial eligibility determination process can be separated from these assessments and combined with other programs' eligibility determinations to reduce the number of required office visits. In child care, an interview may not be necessary to determine eligibility, but the state may wish to provide parents with optional in-person advice and support on how to select a quality child care provider.

  Some states have mail-only application processes for children's health insurance that, in part because of the need for a SNAP interview, do not serve as SNAP applications even when the family appears eligible for SNAP. As a result, families applying for health insurance that would also be eligible for SNAP might miss out on food assistance. Chapter 2 discusses a number of procedural solutions to this problem, such as using a short telephone interview to collect the necessary information to complete a SNAP application, forwarding the application to the agency that administers SNAP, or providing follow-up information on SNAP in the Medicaid or CHIP approval letter.

- **Allow electronic or telephone signatures.** Key to reducing in-person appearances for families is ensuring that the *entire* application process can be done online or via telephone. Online applications (discussed in detail in the next chapter) let families apply for benefits at their convenience 24 hours a day and also establish the date of application. However, if online applications do not offer an electronic signature option, the efficiency they provide is largely undone. Applicants will have to print and sign a "signature page" and then mail or fax it to an enrollment office. This requires a working printer, an envelope and postage, and a trip to the mailbox or post office. It also creates additional tasks for eligibility workers who have to process the incoming signature pages. Further, some states allow electronic or telephonic signatures in some programs but not in others, creating significant confusion for families. Since state law governs electronic signatures, a single coordinated policy across programs may not be too difficult to achieve.

Important note about this option: While decreasing in-person requirements for families is a valuable goal, in-person application processes can be very helpful in some instances. Many families may have limited access to technology or may need help to properly copy paperwork. People with low literacy levels, limited English proficiency, or certain disabilities may prefer or need an in-person meeting. In general, some applicants simply like to speak with a person, and others want to take care of all their business at once: learning about the full range of benefits, applying, being interviewed, submitting any required verification, and receiving confirmation from a person that they have complied with all necessary steps. Finally, face-to-face interaction may afford states an opportunity to provide richer case management services to families facing a broader set of challenges, such as mental health problems, substance abuse issues, or domestic violence.

As discussed in the next chapter, in streamlining their enrollment processes some states have moved to same-day service in local offices, meaning that people who appear in person are likely to walk out that day with SNAP EBT and Medicaid cards in hand. As a general rule, any family that appears in person should have access to the full range of benefits and not be directed to an online, telephone, or mail-in process.

Decreasing, Streamlining and Automating Documentation Requirements

Public benefit programs generally require some form of documentation (or verification) of a family's statements about its income and other circumstances. This requirement enhances program integrity and improves the accuracy of eligibility and benefit decisions. In practice, however, documentation requirements often place a significant burden on families that may not have paystubs or other requested documents or may have difficulty obtaining a photocopy or arranging a fax or scan. In addition, documentation requirements are often inconsistent across programs, making it difficult for families to be sure about what is required. If a family has difficulty securing required documents, its application for (and receipt of) benefits is likely to be denied or delayed.

Documentation requirements also can be onerous for staff. When documents come into an agency piecemeal (as is often the case), state eligibility staff must log them in or scan them, link them to the proper case, and route them to the right staff; an eligibility worker will then have to "touch" the case again to assess the information and approve or deny the application (or send a request for more information). If the application is denied because of incomplete verification, everyone has to begin the process again. All of this additional work creates numerous opportunities for eligible families to fall through the cracks.

So while maintaining strong program integrity is critical to securing public confidence in the programs, onerous documentation requirements can impinge on this integrity by preventing eligible families from gaining access to work supports for which they qualify. (See Box 4 below for a longer discussion of program integrity issues.)

States have considerable latitude in both how much documentation they require from applicants as well as in how they verify the information. Immigration status must always be verified; in Medicaid, states must also verify citizenship, identity, and Social Security numbers, while in SNAP, they must verify income, identity, Social Security numbers, and residency. But beyond these rules, states have

discretion to establish verification policies that decrease burdens and improve participation in work support programs.[25] Below are some changes states may want to consider:

- **Limit documentation to those items required by law.** As discussed above, states can eliminate the asset test so that assets no longer need to be verified. In another strategy, several states — such as **Massachusetts, New Mexico, and Washington State** — have adopted a SNAP policy that accepts a family's attestation on shelter expenses, dependent care expenses, or household composition, unless the eligibility worker finds anything questionable. This helps these states conform their verification requirements to more closely match Medicaid rules and results in fewer "pending" applications and renewals. For the majority of households, once identity and residency are verified, then income is the only eligibility factor requiring verification and, as discussed below, the family need not be the primary source of documentation for this.

- **Allow third-party telephone verification.** In lieu of paper from a family, states can use telephone contacts with third parties, such as landlords or employers, to verify information. For some clients, this approach could represent a barrier to participation, as some people do not want their employers or landlords to know they receive benefits, so this option should only be used with the client's consent. Some states make such third party contacts during the client's interview, either by calling the contact during an in-person interview or by conducting a three-way call with the applicant and the third party if the interview is being conducted over the telephone.

- **Eliminate unnecessary differences in verification requirements.** When states do elect to verify information, it is helpful to have consistent rules across programs about what is needed for common items like income. For example, some states may require the last four weeks of paystubs to verify income for SNAP while requiring the last 30 days' worth of pay information for Medicaid; while the difference is minor, it can cause significant confusion — families may find they have satisfied the verification requirements for SNAP but not for Medicaid because they have provided verification of 28 days' worth of income. States can solve this problem by aligning the policies and giving caseworkers the appropriate discretion to determine when verification is sufficient. In cases where federal rules impose hard-to-meet verification requirements in only one program — such as Medicaid's policy of requiring specific identity and citizenship documents — keeping a more flexible policy in SNAP is vastly preferable to alignment.

- **Only re-verify things that change.** Some states routinely ask for documentation at renewal regardless of whether the item has been verified in the past. Permanent items, such as date of birth or Social Security numbers, need not be re-verified, nor should circumstances that haven't changed or have changed only slightly (e.g., wages from the same employer or housing costs for the same dwelling). Often the state's official policy does not require caseworkers to re-verify items that have not changed, but in practice the workers nonetheless ask for all documentation at every redetermination. States can ensure that computer-generated notices and instructions pertaining to renewals do not inform clients to attach copies of these documents to their renewal forms if the documents are not required by policy.

[25] Verification requirements apply to applicants. Non-applicants, such as parents who apply on behalf of their children, are not subject to these requirements.

Box 4
Ensuring Integrity In Public Benefit Programs

States have a compelling interest in ensuring that work support benefits go only to those who are eligible and are issued in the proper amount. The public must be confident that its dollars are being spent as intended. States generally assess program integrity in two ways:

1. **Conduct documentation checks and data matches as families apply for or renew coverage.** Public benefit programs generally require some form of documentation (or verification) of a family's statements about its income and certain other circumstances. Federal law gives states a significant amount of flexibility in determining what kinds of documentation are required, when other government data sources can be used, and in what timeframes they need to be re-checked.

2. **Undertake periodic, intensive assessment of a sample of cases.** Intensive error monitoring generally takes place on a program-by-program basis.

    - **SNAP:** The SNAP program's Quality Control (QC) system reviews a statistically valid sample of cases each month. QC reviewers conduct interviews with families to verify that the state eligibility worker made the correct eligibility determination and issued the proper benefits. Some 50,000 cases are sampled annually. Federal re-reviewers assess a subset of these cases to check the accuracy of the state's QC findings. States with high error rates face fiscal penalties.

    - **Medicaid and CHIP:** All states participate in the Payment Error Rate Measurement (PERM) system, as well as conduct Medicaid Eligibility Quality Control (MEQC) activities. PERM requires states to pull a sample of cases every three years to review the accuracy of eligibility decisions (and payments to medical providers and managed care plans). The PERM eligibility reviews are relatively new and have produced some unreliable error rates that have discouraged some states from simplifying their eligibility procedures to maximize enrollment among those who are eligible. The rules for these reviews have been repeatedly amended since they were put in place, most recently this past year. Because states have their own funds invested in providing health benefits, many augment PERM with their own program integrity systems, sometimes integrated with the SNAP QC system.

Finding the Right Balance

Over the years, data from these various assessment mechanisms have shown that the great majority of improper payments in work support programs do not result from fraud, but rather are due to honest mistakes by eligibility workers or families. Complex program rules and the rapidly changing (and often unstable) circumstances low-income families face contribute to these occasional errors.

At the same time, burdensome paperwork requirements can conflict with other goals of the program — most notably, ensuring that eligible families have access to critical work supports that can prevent extreme hardship and help them to improve their circumstances.

Balancing the need for documentation with the actual incidence of fraud and with overall program goals is key. As discussed in this paper, states can adjust their eligibility requirements to achieve all of these goals. For example, recent state-level research has found that when children's health coverage programs reduce income verification requirements, they do *not* see a rise in error rates. Similarly, when states (such as Massachusetts, New Mexico, and Washington State, as discussed above) have dropped verification of shelter and child care expenses and other factors for SNAP, they have not seen a rise in their SNAP error rates.

- **Only verify things that affect eligibility.** States can train eligibility workers to identify when verification of certain items of eligibility is not necessary for a given family. The computer system also can be programmed to indicate this to the eligibility worker. For example, a family with no current income automatically qualifies for the maximum SNAP benefit as well as Medicaid; there is no need to verify shelter expenses or child care arrangements. Similarly, if a family is not seeking retroactive Medicaid coverage for prior medical expenses, there is no need to verify the amount of income from a job a person no longer has.

- **Proceed without verification if the information is not questionable.** Some states retain an expanded list of verification requirements but do not deny or "pend" an application if some of the items on the list are missing unless the family's statements are questionable. For example, a state's instructions to families for SNAP verification may include providing proof of rent and utility costs. If the family does not provide this information but its statement on the application seems reasonable, the state can processes the application with that information. Since most families will provide the information if they can, this approach can limit the number of times a state needs to "touch" a case. At the same time, by maintaining a lengthy list of requirements, states may be requiring families to chase down verification unnecessarily.

Important note about these strategies: If a state has concerns about the effects of these various strategies on program integrity or state expenditures, it can test them on a subset of the population (e.g., among more stable families, at renewal rather than initial application, or in a limited geographical area) before establishing the policy statewide. Following such a test, if the state decides a specific verification requirement has "low payoff" — i.e., it prevents relatively few errors but significantly increases paperwork burdens — then the requirement can be removed (except in under certain criteria that the state establishes where the information the family has provided or the state has obtained is questionable.)

The state's Quality Control system or other audits can provide data on the "pay-off" of various forms of verification. Reliable data on case closures and the frequency of denial codes, in particular, can show which types of verification are most likely to contribute to procedural denials. (A procedural denial or closure is one where the family remains eligible, but loses benefits for failure to comply with a procedural requirement, such as providing verification. For more information about use of data in setting policy and procedures, see Chapter 3.)

Sharing Verifications Across Programs

As described above, most low-income families are eligible for more than one work support benefit, and states can allow information verified in one program to determine or update eligibility for another program. Sharing verification in this way reduces the number of times a family must provide the same documentation to various agencies or caseworkers. For example, families without health problems may be most likely to inform their SNAP or child care caseworker about changes in their circumstances (such as a new address) because those are the benefits they rely on most. Rather than require families to provide this information to Medicaid as well, the state should allow Medicaid caseworkers to simply check other programs for the most recent information.

States can undertake information-sharing in a number of ways. For example, they may wish to consider policies that enable routine sharing of scanned images of permanent verification

documents, such as birth certificates. Or, they can provide "look-up" capabilities, with client consent, so that workers can check to see if income verification, changes of address, or other items have been submitted recently for another program. In **Illinois,** eligibility for the child care program is typically determined by local non-profit child care resource and referral agencies (CCRRs). While these agencies are separate from the Illinois Department of Human Services (DHS), they have access to the DHS computer system. This allows them to look up a household's SNAP and Medicaid record, which often contains most of what the CCRR needs to determine eligibility for child care subsidies. This practice reduces redundant paperwork for families and increases agency efficiency.

Another information-sharing strategy is to give certain programs (such as LIHEAP or WIC) the ability to electronically confirm a household's participation in SNAP or Medicaid, after obtaining the client's consent, if they require such confirmation for eligibility or other purposes. This is far more efficient than asking families to visit the local welfare office to get a printout confirming their participation.

For any of these strategies to succeed, verification information must be available in a range of formats. For example, a Medicaid worker will only be able to use income information from SNAP if it is available *by individual,* not just by household. Similarly, cross-checking is most feasible when states align, as closely as possible, what counts as income or assets in their programs, or implement eligibility rules that allow determinations from one program to establish eligibility for another. States hoping to increase sharing of verification information will need to think through these issues and plan accordingly.

Using All Available Data Sources

A verification requirement — whether in federal law or state policy — does not, by definition, mean that the family applying for benefits is responsible for securing the verification. In many instances, states can independently verify or corroborate families' statements using electronic data matches or information from other agencies. In fact, under SNAP rules, states cannot require a specific piece of paper (such as a paystub or birth certificate) to verify a given element of eligibility, and they must assist the applicant in gathering information by accepting alternative documents or conducting data matches or third-party telephone calls.

Some 12 states do not request paper documentation from families applying for health coverage for their children. Instead, the agency first looks to other sources to verify income before placing the burden of verification on families. There are many information sources available to verify income and other eligibility factors:

- **Federal databases.** States have long had access to many federal databases to verify items such as Social Security numbers, SSI and Social Security income, and Unemployment Insurance income. A new Social Security Administration data match is available to states for verifying citizenship and identity for Medicaid and CHIP; as of December, 2010, 32 states were implementing this option. And, the health reform law will establish a new process by which public benefit program can access a broad range of federal databases (and potentially state data as well).

- **State databases.** State databases have information on wages, addresses, new employment, motor vehicle records, drivers' licenses, child support income, workers' compensation, energy assistance, and some child care co-payments, among other items.

- **Commercial databases.** Payroll data companies, such as The Work Number, can provide employment and current income information for certain employers at a modest cost to states.

- **Program files.** As described above, some states have a "paperless file" system in which information from one program is immediately available to other programs.

With all of this data available across a wide range of different sources, several states have sought to simplify data collection for eligibility workers by installing a "gopher" system that looks up all matches and presents a consolidated report within seconds. These systems save eligibility workers from having to query each data source separately. See page 63.

Important note about this strategy: While electronic verification through existing databases holds great promise for lowering the burden of paperwork on families and state agencies, database information is not always accurate. For example, databases of newly hired individuals and state wage information might be outdated — the person may have been hired and subsequently lost the job, for example — or the employer may have erred in entering the information. Similarly, federal sources of information on immigration status may not be updated to reflect an individual's subsequent naturalization. State agencies should have a process in place that gives families an opportunity to challenge and correct information that the state has obtained through data matches.

Policies that Simplify Renewal and Increase Retention of Benefits

Research shows that the month when eligibility and benefits must be redetermined is a significant risk point for families participating in work support programs: they are more likely to lose their benefits during this time because they are unable to successfully navigate the renewal process. A loss of benefits can precipitate household crises — it may leave a family without enough food, unable to see a doctor when a child is ill, or without the child care arrangement that enables the parents to keep their jobs.

But continuity of benefits is a matter of urgency not only for families; for states facing budget crises it is also critically important. Traditionally, states have sent renewal applications to families and waited for the applications to be returned. If they are not returned, the case is closed, often resulting in the family applying again within a few weeks to reopen their benefits. This type of "churning" is an enormous waste of caseworker and agency time.

Consider a state that has a caseload of 120,000 families. If the state must reestablish eligibility for each family once a year, and one-third of those families fail to renew on time yet remain eligible and subsequently reapply for benefits, the state must unnecessarily process an additional 36,000 applications a year. Further, this example assumes that renewals are coordinated across programs. If the state must do a *separate* SNAP and Medicaid renewal each year, or separate SNAP, Medicaid, and CHIP renewals, then the number of unnecessary applications increases several times over.

Given these numbers, decreasing churning should be a high priority for states. Improving the renewal process is a key strategy because these families are known to the agency and renewal procedures can take full advantage of the significant time already expended on establishing initial eligibility. Many of the enrollment simplification and coordination policies discussed above — e.g., reducing documentation requirements and sharing data across programs — also will yield dividends at renewal time. Following are additional retention-specific strategies in three areas:

- Coordinating and simplifying renewal activities
- Aligning change reporting rules
- Quickly re-establishing eligibility following a break.

Coordinating and Simplifying Renewal Activities

All families must periodically renew their eligibility for work support programs. Unfortunately, renewal philosophies, time periods, and processes can vary widely across programs. For example, in SNAP, states must use fixed certification periods (no longer than one year) and must obtain a new, signed application from the family at the end of the certification period. Most states' TANF and child care programs also use fixed eligibility periods, though they are not required to do so and the time periods and paper requirements may be different. In health coverage programs, although federal rules require redetermination of eligibility at least once a year, families are considered eligible until they are shown to be ineligible (because of changes to their income or circumstances or because they do not complete the renewal process).

Fortunately, states have significant flexibility — particularly in renewal of health care coverage — to coordinate and streamline renewals, as outlined below. It is important for states to think about their renewal periods in combination with their change reporting policies (discussed next).

- **Use the longest eligibility periods available.** While most states renew Medicaid/CHIP eligibility only once a year, many still review SNAP eligibility every six months. Using annual eligibility periods across all programs saves time for state workers and keeps families enrolled.

- **Combine renewals.** To complete the renewal process, different work support programs require much of the same information about family income and circumstances. By combining efforts — i.e., when renewing for one program a family is automatically or simultaneously renewed for another — states can greatly increase efficiency. For any given family, combining the renewals across SNAP and Medicaid could cut the state's total effort on renewals in half.

  Important note about this strategy: When renewal processes for SNAP and Medicaid/CHIP are combined, states should design the process to ensure that Medicaid and CHIP are not terminated if the SNAP recertification fails to be completed. In such an instance, the family would keep its health coverage through the original renewal period. At that point, there would also be an opportunity to rescreen and enroll the family in SNAP.

- **Push eligibility forward.** When updated information is collected for one program, the state can extend eligibility in another program without requiring a separate renewal process. This sometimes is called "rolling renewals." For example, when a family recertifies its eligibility for SNAP (or submits the required "check-in" report at the six-month mark) the state can use the

information gathered as a part of the SNAP renewal to bump forward the family's Medicaid or CHIP eligibility period another 12 months without requiring the family to submit additional paperwork. This strategy also can be used if eligibility periods fall out of alignment: they can be quickly realigned by pushing the Medicaid eligibility period forward.

Important notes about this strategy: Because of differences in work support program rules, pushing eligibility forward may work best when SNAP is the originating program. When a family completes a renewal for health coverage, the eligibility worker typically will not have all the information to recertify SNAP (e.g., data on certain deductible expenses and on SNAP household members not applying for health coverage). In addition, SNAP requires fixed eligibility periods and a recertification application with a signature, while health programs allow flexibility in these areas. If additional information is needed for another program (such as data on private health coverage or hours of work for child care), questions can be added to the SNAP simplified report or recertification form along with a note explaining that this information is not required for SNAP purposes. In addition, as with the option to combine renewals, it is important to note that Medicaid and CHIP should not be terminated if a family fails to complete its SNAP recertification.

- **Allow renewals by telephone or Internet.** States typically use the mail for renewing benefits, but the telephone and/or Internet also can be used effectively if the state is able to accommodate such applications (specific procedural options in this area are detailed in the next chapter). Only the SNAP program requires a signature on an application for recertification, but the signature can be electronic or telephonic.

- **Pre-populate forms.** States can simplify the renewal process by pre-populating renewal forms with the most recent information the agency has (such as on household members or income) and then asking for updates as opposed to re-entry of data. If there is no change, there is no need to re-verify the information.

- **Establish a policy vision that gives special attention to cases that are about to close at renewal.** In many states, the system closes a case automatically if the renewal process is not completed by a certain date. These "auto-closures" can occur frequently and can put a family's entire support package at risk. Further, there are often legitimate reasons to keep a case open: the proper documents may have been submitted but not yet logged-in; a single missing piece of information could quickly be verified elsewhere; an individual with a disability or literacy issue may require special assistance. States can investigate cases that are about to close and, with a minor amount of work, keep them open. Similarly, cases often close at renewal because families that have moved do not receive the renewal packet. To minimize these terminations, states can analyze their returned mail, try to establish telephone contact, or locate an updated address through a match with another state program or the Department of Motor Vehicles.

Aligning Change Reporting Rules

In addition to having their eligibility re-determined annually, participants in work support programs generally are required to keep the state informed, between eligibility reviews, about changes in household circumstances (such as in income or household composition). States' approaches to change reporting fall into three categories:

- **Immediate change reporting.** Recipients must report specified changes in income or circumstances promptly, usually within ten days. Caseworkers must adjust eligibility and benefits to account for the change. This is the most common type of reporting requirement in Medicaid, CHIP, TANF, and child care.[26]

- **Periodic reporting.** Recipients periodically must submit a report on specified elements of eligibility, even if nothing has changed. Periodic reporting is used most often in SNAP, as discussed below, with reports generally required every six months. If the report is not received by the deadline, the case is closed. If a state receives information between reports, it may have to make a change at that time.

- **No reporting (or "continuous eligibility").** Virtually no reports are required between eligibility reviews other than very fundamental eligibility changes, such as moving out of state or the death of a household member. Continuous eligibility is an option in Medicaid for children and, with a few exceptions, can be used for other Medicaid recipients as well as in TANF and child care.[27]

Over the last decade, nearly all states have adopted a federal SNAP option called "simplified reporting," which has vastly reduced requirements for workers as well as participating families. Under simplified reporting:

- Recipients must submit updated information about selected household circumstances (e.g., composition, income, change in residence) every six months through a mail-in report form or the recertification process.

- Between simplified reports (or recertifications), changes in income need only be reported if the increase takes the household above 130 percent of the poverty level. Other changes, such as loss of income or change in the number of household members, can be reported in order to document eligibility for increased SNAP benefits.

For programs other than SNAP, by the end of 2009, 22 states were using continuous eligibility to eliminate interim reporting for children enrolled in Medicaid and 30 states were using continuous eligibility in CHIP. The majority of states, however, have not simplified reporting rules in other programs such as Medicaid for parents, TANF, or child care. For these programs, most states still require *all* changes that might affect eligibility to be reported within ten days.

Because so many families in need receive benefits across these programs, the failure to be consistent can render moot the improvement made in any individual program. For example, although SNAP reporting has been streamlined, states may still require families receiving family

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[26] Medicaid regulations require states to "have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility." States currently have significant flexibility to design reporting rules that meet this requirement. See 45 CFR § 435.916(b).

[27] HHS has not yet clarified whether under health reform states will retain the ability to provide adults with continuous eligibility in 2014 and later years.

Medicaid, TANF, or child care to report any change in their circumstances within ten days. As a result, the state has not reduced the overall reporting burden that families face. Further, SNAP rules might require that a caseworker gather verification of income changes reported to another program and then adjust the family's SNAP benefits based on the new information, despite the fact that the change did not have to be reported to SNAP in the first place.

Fortunately, federal law allows substantial flexibility when it comes to change reporting, so states have opportunities to rectify inconsistencies and cross-program conflicts. States can:

- **Reduce reporting requirements in all work support programs.** States have broad latitude to set reporting requirements in work support programs other than SNAP. As noted, in Medicaid and CHIP, they can adopt continuous eligibility for children. Using the "less restrictive methodologies" option, they can also disregard many changes for parents' Medicaid eligibility.[28] In TANF and child care they have flexibility to limit instances in which change reporting is required. Most states have not thoroughly examined the options available to them for lowering the reporting burden. As a result, they receive — and must respond to — more change reports than are actually necessary.

- **Delay action on data matches.** Many states routinely run data matches for their entire caseloads to check for new information on participating families. However, this practice can actually increase error rates and administrative burdens. Depending on the data source, the match may not be current or complete enough and may require additional contact with the household; state staff may act improperly on the information.

  For example, a state may run a data match of client records with out-of-date state tax data which shows that a few months ago a client's monthly income was $2,000. If the client demonstrated last month that his income is $1,000 due to reduced hours, the data match may not be sufficient cause to require the client to re-verify his circumstances. It is therefore beneficial for both families and the state agency to adopt a policy of delaying action on data match information until households come up for recertification (or in SNAP, until the next simplified report is due) unless the information appears to indicate that the family is ineligible.

  After 2014, this approach will have an important qualifier. When low-income families receive tax credits to help pay premiums in the exchange, it will be important to use data matches to notify families that they need to modify the level of assistance they receive. Otherwise, if a family receives excess tax credits compared to their annual income reported on tax returns, the family will need to repay some or all of the value of the extra credits received during the year.

- **In SNAP, act only on changes that would increase benefits.** Under SNAP simplified reporting, if a state learns of a change that was not required to be reported, it can choose to act only if doing so would increase the household's SNAP benefits. There is an exception to this: if a state gets information from an original source (e.g., the Social Security Administration or the state's Unemployment Compensation agency) it is considered "verified upon receipt" and must

[28] HHS has not yet issued rules on change reporting under the health reform law. It is expected that these rules in Medicaid will dovetail with the reporting rules for the subsidies that higher-income families and individuals will qualify for through state exchanges.

be acted upon. Otherwise, all change information that would *decrease* benefits can be acted on at the next recertification or report.

Unfortunately, many states have opted to act on reported changes that would increase *or decrease* benefits. States indicate that acting on changes in only one direction requires significant computer reprogramming. However, since many states are considering new computer systems, there may be an opportunity to resolve this concern. States that act only on changes that increase benefits include **Missouri, Oregon,** and **South Carolina.** This policy saves states time because they do not have to act on as many changes; it also modestly increases benefits for families.

Quickly Re-Establishing Eligibility After a Break

The following sequence of events is not uncommon: families fail to take all required actions in a timely manner; the state responds by denying or terminating eligibility; families subsequently come up with the required information, but must begin an application from scratch, as though they were completely unknown to the state. Given that it is much less burdensome to simply reopen an existing case than it is to start a new process, states should consider:

- Using the flexibility offered in health coverage programs to allow re-opening of recently closed cases (or denied applications.)
- Seeking waivers from the USDA to expand their ability to re-open SNAP cases that they have closed in the middle of a certification period.
- Authorizing caseworkers to reestablish eligibility based on a telephone call or data matches with authoritative sources of information if no further verification is required.
- If a new application is required, pre-populating the application with the information that is known to the state and using permanent verification in the case file to satisfy any items that have not changed.

Making Integrated Policy Changes Happen

Once new policies are on the books, state human services officials can and should take steps to ensure that the changes are effectively implemented and achieve their full benefit. Among the many possible actions they can take, the following are particularly critical:

- Publish joint policy and conduct joint trainings
- Systematically monitor implementation of new policy.

Publish Joint Policy and Conduct Joint Trainings

State policy officials often operate in separate silos even when their programs are integrated at the local level. This can create confusion all the way down the line. For example, even if eligibility workers in the local office are conducting integrated interviews and eligibility determinations, the

policy manuals they are using, as well as their training sessions for SNAP and Medicaid, may be separate. As a result, the burden of sorting out policy differences falls on the eligibility worker and the family.

This can be avoided if policy officials work together, meeting and talking regularly to ensure that the rules are as consistent as possible across programs. They can coordinate and present joint policy to local offices, whether in policy guidance directives, procedure manuals, or staff trainings. Where rules are not consistent, making the differences transparent to workers and families is important. When policy questions arise, the two programs' policy officials can sort through the federal and state regulations together and provide an integrated answer.

Systematically Monitor Implementation of New Policy

Adjusting policy directives and manuals is not always sufficient to ensure that changes happen consistently in the field. Eligibility workers may continue old policies and practices out of habit, because they do not understand the rationale behind the change, because they are overwhelmed and not keeping up with written policy changes, or because they think the policy may be reversed in the future. For example, protecting against the possibility that an asset limit may be reinstated, a caseworker may continue to collect information on a family's assets to demonstrate that it is not over the limit; while the caseworker's intention is honorable, such a practice sustains paperwork burdens that were meant to be removed. In addition to getting the word out and conducting training on the new policy, states can monitor implementation through data collection (discussed at length in Chapter 3) and during supervisory reviews.

Oklahoma has a state policy to coordinate eligibility periods across SNAP and Medicaid. To ensure this policy is being carried out, the state uses data from its eligibility system to periodically tabulate, by local office, the share of cases that have eligibility periods out of alignment. Other states have included this kind of systematic check on policy compliance in supervisory reviews. For example, a supervisor might check the cases she normally reviews to make sure eligibility workers are not asking for more documentation from families than is required.

This chapter has focused on a range of policy options states can pursue to increase families' access to critical work supports. Chapter 2 builds on these policy directions, laying out a series of specific processes and procedures that states can put in place to get the work done.

Chapter 1: Policy Resources

Multiple Programs

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