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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Why It Is Critical to Address Program Integration Issues in Health Care Reform

By making affordable health care available to millions of low-income, uninsured Americans, the Affordable Care Act (ACA) will go a long way towards helping families who struggle on a daily basis to afford life’s most basic necessities. Health care reform’s impact on low-income people’s lives, however, goes beyond providing them health insurance coverage. It has the potential to significantly affect low-income individuals and families’ ability to apply for and receive other benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and child care subsidies, that are critical to helping them make ends meet.

In states that expand Medicaid eligibility in 2014, it is likely that a large share of people (mostly parents and adults without children) who will be newly eligible for Medicaid coverage will already be enrolled in SNAP or other benefit programs. In other cases, individuals who apply for health coverage due to the new law will not have had contact with state human services in the past and many may be eligible for other benefits, such as SNAP, child care subsidies, or energy assistance. Considering how to address and leverage applicants’ or participants’ connection to other benefits and services is important for several reasons.

Integrated Processes Avoid Duplication and Help States Respond Cost-Effectively to Elevated Need

Maintaining or building duplicative processes for programs with similar eligibility rules is inefficient and costly. Integrating processes across multiple benefit programs can help states manage their resources, which will face increased demands under the ACA. States are already struggling with the significant increase in program caseloads brought on by the most recent recession. While the state of the economy is improving, it will take several years for unemployment levels to drop, and the demand for state services and supports related to programs such as Medicaid and SNAP is unlikely to relent anytime soon.

States also will face a significant challenge in processing applications for large numbers of individuals in 2014 and future years. The requirement that people have health insurance, along with outreach that will

All States Must Make Changes to Medicaid

The ACA leaves it up to states to decide whether or not to expand Medicaid to cover most low-income adults with incomes up to 133 percent of the poverty line. Other aspects of the ACA that change Medicaid eligibility and processing are requirements. Consequently, all states will still need to make changes to its eligibility processes and procedures. States will still have to use a single, streamlined application for Medicaid and exchange premium subsidies, adopt a new methodology for calculating income and household size, and increase its use of electronic verification methods.

Whether or not a state expands its Medicaid program, these required changes will have an impact on linkages the state may established between Medicaid eligibility and eligibility for other programs such as SNAP. For example, states that now have a multi-benefit application will need to assess how the requirement to use of the single-streamlined health application will impact the use of the current application and the state’s ability to connect applicants to multiple benefit programs.

As such, a state will still benefit from the tools and exercises provided in this toolkit regardless of its decision regarding the Medicaid expansion.

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1 CBPP estimates that approximately one-fourth of SNAP participants will gain Medicaid eligibility under the ACA. In some states this share is as high as 47 percent.
publicize the health reform’s coverage expansions, will result in millions of people applying for insurance affordability programs, many of whom will qualify for Medicaid. What’s more, as people who have not had contact with state human services in the past learn about other state administered benefits, such as SNAP and child care subsidies, when they apply for health care coverage, applications for those programs may also increase.

At the same time that caseloads are increasing, states continue to face large budget gaps and are struggling to find the revenue needed to support critical public programs. Thirty states have projected (and in some cases have already closed) budget gaps totaling $49 billion for fiscal year 2013. Unfortunately, states’ options for addressing these shortfalls are more limited and involve tougher trade-offs than in past years.

Given the combined pressures of limited budgets and increasing caseloads, states have little choice but to eliminate systemic redundancies and develop more efficient processes so they can do more with fewer resources.

Integration with Human Services Is a Cost-Effective Way to Enroll New Medicaid Eligibles

For states that expand Medicaid, integration with human services programs will be an important strategy to reach individuals newly eligible for health coverage in 2014. As mentioned previously, many of the people who will be newly eligible for Medicaid are already in contact with state human services. Federal SNAP income eligibility is 130 percent of the poverty line, which means that most SNAP households have at least one member — often a child — who is eligible for Medicaid now.

The overlap in SNAP and Medicaid eligibility will be even greater in 2014, when these states extend Medicaid coverage to parents and childless adults with incomes up to 133 percent of poverty. In fact, many low-income parents and adults without children who will gain Medicaid eligibility in 2014 are currently eligible for and receiving SNAP benefits. A Center on Budget and Policy Priorities analysis found that if all states expand Medicaid, about 6 million adult SNAP participants will likely become newly eligible for the program. In more than half the states, more than 50 percent of current SNAP households contain a member who will be newly eligible for Medicaid in 2014 (see Figure 1). In addition, an estimated 95 percent of non-elderly individuals who are on SNAP will be eligible for Medicaid (including individuals who will be newly eligible as well as those who are currently eligible but not enrolled in Medicaid).

Because the state already knows who is receiving SNAP, streamlining enrollment policies and practice so people on SNAP can be automatically (or more expeditiously) enrolled in Medicaid in 2014 will be an important strategy for responding to the pending enrollment surge and ongoing workload. SNAP has a very high participation rate among those eligible for the program — over 80 percent among families with children and over 60 percent among non-elderly, childless adults — so using SNAP participation as a way to connect eligible parents and other adults to Medicaid will be an important outreach tool.

Moreover, states already spend considerable effort rigorously evaluating income for SNAP participants at least every six months, and participants are required to report changes in income that would make them ineligible (known as threshold reporting) so this information should be considered timely and accurate. It would be good practice for states to make SNAP information available to the Medicaid program.

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3 Center on Budget and Policy Priorities analysis of SNAP Quality Control data for fiscal year 2010.
Integrating Technology Up Front Is Cost-Effective for Both Human Services and Medicaid, Especially with High Federal Match

When developing new systems, it is always most cost-effective and efficient to build in cross-program coordination capacity from the start, rather than retrofitting the technology later. In addition, the federal government is providing financing for Medicaid systems development, making it even more economical for states to integrate technology up front.

The vision for health reform is that it will use modern business techniques — that people interested in coverage will apply online, and much of the process for documenting their eligibility will occur in real time, based on electronic data matches. To help achieve this vision, U.S. Department of Health and Human Services (HHS) will provide states with an enhanced federal Medicaid match (90 percent) to support the design, development, testing, and implementation of new or enhanced eligibility systems.

In addition, joint guidance issued by HHS and the U.S. Department of Agriculture (USDA) says that states need not allocate the costs involved in developing the information systems to support eligibility determinations for Medicaid and the Children’s Health Insurance Program (CHIP), regardless of whether other programs benefit. The state must charge only the incremental costs for additional requirements to integrate non-health programs to those specific programs, at the lower match rate provided by those programs. States will benefit from the 90 percent match and temporary waiver of cost-allocation rules through December 31, 2015. HHS also will provide an ongoing 75 percent match once such systems are operational.

Source: Center on Budget and Policy Priorities analysis of SNAP Quality Control Data for fiscal year 2010.
Thus, states can design and build the basic technological infrastructure (e.g., hardware, rules engines, client correspondence mechanisms, interfaces with other systems) of an integrated system for Medicaid and receive the 90 percent match, and then supplement it with additional “modules” for other programs (and get reimbursed separately by those programs). Because states already have to upgrade and redesign their Medicaid eligibility systems, this is an excellent time to consider integrating other programs and their corresponding enrollment systems.

The ACA Requires IT Systems that Facilitate Integration

The ACA envisions that states will connect individuals applying for health coverage to other human services benefits. It requires states to seamlessly connect individuals eligible for health coverage in Medicaid, CHIP, or the exchange to the right program, regardless of where they apply.

For example, Section 1561 of the ACA requires HHS to establish standards for how new information technology systems will support applications to the health care exchanges that also connect families to other human services benefits. State Medicaid systems must meet these standards to qualify for the 90 percent federal match. In addition, the Medicaid eligibility rules require states to use data from other human services programs — and specifically SNAP — to verify information provided by applicants to establish Medicaid eligibility.

These requirements for developing interoperable systems and sharing data across programs will be critical to helping families apply for and keep benefits. SNAP income data are no more than six months old, and because the program’s verification and reporting rules are strong — states are subject to rigorous SNAP quality control review and associated penalties for low accuracy — the data are reliable. Thus, by tapping into the their SNAP databases, states can ease some of the burden — on both clients and caseworkers — involved in documenting and verifying income information for Medicaid eligibility. Using this process, states should be able to dispatch these cases more quickly, enabling them to focus more on Medicaid applicants who are new to the system.

Without Integration, Low-Income People Could Actually Lose Medicaid Coverage

Past experience has shown that major eligibility system changes can lead to families losing benefits. In the late 1990s, after the implementation of welfare reform, Medicaid enrollment declined substantially. While part of the enrollment declines could be attributed to a strong economy, difficulties with the administration of benefits also played a key role. For example, in some eligibility systems, Medicaid and Temporary Assistance for Needy Families (TANF) eligibility were not considered independently so that Medicaid benefits were inappropriately terminated when a family left welfare. In other cases, families did not have a way to apply only for Medicaid benefits without having to fill out a combined Medicaid and TANF application.

Major systems changes bring major risks to poor families, and ACA implementation is no different. With the health community’s new focus on ensuring seamlessness across insurance affordability programs (Medicaid, CHIP, and premium tax credits), states should not lose sight of the importance of coordinating with human services programs as well.

In particular, in states that co-administer Medicaid eligibility with eligibility for other human services programs, splitting off these functions poses a serious risk (at least in the short term) that individuals and families will lose coverage. In these states, many low-income people are accustomed to going to a single place — the local welfare office — to apply for multiple benefits. Despite efforts to provide new ways for people to apply for and renew benefits, such as online or by phone, a core group of people will continue to seek benefits in person through the local welfare office.
If states change their processes so that individuals can no longer apply for Medicaid through those offices, or they create an additional step to obtaining coverage outside of a household’s regular SNAP or children’s health insurance renewal process, these individuals may not apply for Medicaid at all, or they may wait until they experience illness before seeking it out. Maintaining a solid connection between human services and Medicaid is a sensible approach for the lowest-income people and ensures that those who apply for benefits through the human services door also have a path to Medicaid.

A Complete Package of Supports is Most Beneficial for Struggling Individuals and Families

Perhaps the most important reason for engaging in cross-program integration is that providing the poorest individuals and families access to the full package of benefits for which they are eligible is critical to helping them make ends meet and stabilizing their circumstances. Too often, poor families with little to no disposable income are faced with very difficult choices, such as delaying payment on the utilities to seek health care for a child, or going into debt to pay rent or put food on the table. Programs such as Medicaid, SNAP, child care subsidies, housing assistance, and others are important to supporting these families and putting them on a path to self-sufficiency.

Helping families overcome poverty and become more self-sufficient requires a coordinated approach to delivering benefits. Research has shown the positive impact that each of these programs have on families. SNAP protects poor families from hardship and hunger. Parents who receive child care benefits are better able to pay their bills on time and provide for their children. Children on Medicaid and CHIP have better health and educational outcomes. Receipt of just one of these benefits makes a significant difference to a low-income family. But lifting most families out of poverty requires providing them with the full range of supports that are available. Providing a family with health coverage but failing to connect them to other benefits like SNAP and child care is a missed opportunity to give these families the supports they need.

The Big Picture: Health Reform’s Implications for Program Integration

The ACA will dramatically increase the number of people with access to affordable health care starting in 2014. Currently, Medicaid covers many low-income individuals but leaves significant segments of people out. It generally does not cover adults without dependent children, and only covers parents at very low income levels. Medicaid eligibility also varies significantly from state to state. For example, some states cover children up to 400 percent of the poverty line, while other states have lower income eligibility thresholds. In a handful of states, parents cannot qualify for Medicaid if they earn more than 24 percent of the poverty line (or $5,763 per year for a family of four). Figure 2 shows at what income levels people can be eligible for Medicaid in the median state.

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As passed, the ACA required states to expand Medicaid eligibility to cover most non-elderly, non-disabled individuals with incomes up to 133 percent of the federal poverty line (FPL), or about $30,700 for a family of four. This expansion of Medicaid is a significant improvement in coverage over current law and is the foundation of coverage initiatives in the ACA designed to ensure that all Americans have a pathway to health coverage. On June 28, 2012, the Supreme Court upheld the constitutionality of the ACA but found that it would be unconstitutional to withhold federal funds for a state’s existing Medicaid program if the state did not expand coverage. The decision thus leaves it up to the states to decide whether or not to expand their programs to cover low-income adults. The Supreme Court’s decision leaves all other provisions of the ACA in place. Thus, states still must make other Medicaid changes, such as using a single, streamlined application for Medicaid and exchange premium subsidies, adopting a new method for calculating income and household size based on Modified Adjusted Gross Income (MAGI) rules, and shifting towards electronic verification of information.

In addition to the Medicaid expansion, those with incomes too high to qualify for Medicaid but earning less than 400 percent FPL will be eligible to receive premium tax credits to help defray the costs of purchasing coverage through the newly established exchanges. The Congressional Budget Office estimates that by 2022, eight years after the coverage provisions go into effect, 33 million Americans who otherwise would be uninsured will gain coverage. About half of these, or 17 million people, will newly enroll in state Medicaid programs.

5 The ACA does not increase the income eligibility threshold for the elderly and disabled individuals. In addition, legal immigrants who do not meet the five-year residency requirement will not be eligible for Medicaid but will be eligible to receive premium tax credits. The federal government will assume 100 percent of the Medicaid costs of covering newly eligible individuals for the first three years that the expansion is in effect (2014-2016). Federal support will then phase down slightly over the following several years, and by 2020 (and for all subsequent years), the federal government will pay 90 percent of the costs of covering these individuals.

The health reform law will bring enormous changes to states in 2014. There will be a huge influx of new people interacting with the Medicaid program, as well as many new rules for determining Medicaid eligibility. These new rules—which both expansion and non-expansion states will be required to implement—emphasize a “no wrong door” system for eligibility that connects eligible individuals to the right health coverage program regardless of where they apply, and harnesses technology to minimize or eliminate unnecessary paperwork. As a result, states will have to change their application forms and procedures (including forms and processes that encompass other programs), significantly upgrade their eligibility systems, develop methods for rapidly accessing data and verifying information provided by applicants, and rethink how they conduct business to fit health reform’s vision of a simple, streamlined eligibility and application process.

Whether states expand Medicaid and how they respond to the required changes in eligibility processes will be influenced by where they fall in the health care coverage spectrum, the needs of the clients they serve, what policies and processes they currently have in place, the resources that are available, and their programmatic priorities. But regardless of how a state chooses to address the ACA requirement, what is clear is that the changes that states will need to make to their Medicaid programs will necessarily have a significant impact on the administration of other human services programs as well.

Recognizing that most families who are eligible for Medicaid may also be eligible for other human services programs and vice versa, many states have embarked on efforts to make it easier for families to access such services. For example, today, more than 40 states have integrated Medicaid and Supplemental Nutrition Assistance Program (SNAP) processes for families that apply through the welfare office, and almost all states have an application that can be used to apply for multiple types of benefits. As states move forward with health reform implementation, it is important to maintain these linkages and to make sure that low-income families do not face more barriers to accessing the programs and services that they need. States will need to tackle these key questions:

- How will people who apply for human services programs be informed about and connected to Medicaid? As noted, in most states, families that apply for benefits at a local human services office are routinely screened for and, if eligible, enrolled in health coverage. Will that still be the norm in 2014? Or will the poorest families face added burdens to accessing health coverage because they can only seek health benefits through some other process?

- How will low-income people who apply for health coverage through the state’s online application be connected to other human services programs and benefits? When low-income individuals apply for health coverage and qualify for Medicaid, will there be a process to help connect them to other benefits and services for which they might be eligible?

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A Different Kind of Different

Medicaid eligibility was set up under health reform to align with the subsidies available to purchase exchange coverage which will be administered through the tax code. As a result, many of the new rules in both programs originate in the tax code rather than traditional benefit programs. These differences can make coordination more difficult, but not impossible. It’s important to remember that Medicaid, SNAP and other human services programs have long had some key differences, particularly with respect to household composition and some income counting rules. Despite their individual rules, many states have had tremendous success in co-administering and coordinating these programs. The new differences need to be understood and addressed. Although they may be frustrating, they are not insurmountable.

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Put another way, will it be harder or easier in 2014 for the poorest families to access the package of services for which they will be eligible, including health coverage?

State choices with respect to these issues will have an enormous impact on poor families’ and individuals’ access to key benefits and services. To be sure, health reform implementation alone presents an enormous challenge for states. Because of the tight timeline for changing Medicaid eligibility processes and setting up the exchanges, some states might be tempted to wait until the law is fully implemented before addressing these cross-program integration issues, but this could lead to missed opportunities and make it harder to take these issues into account down the road.

**State Choices for Implementing Health Reform and Integrating Programs**

States face myriad choices in designing their enrollment pathways: should they offer applicants the ability to apply simultaneously for multiple programs? How do they ensure paper documents from clients get to the right caseworkers in time to support a decision? What is the best way to answer families’ questions about their benefits? The manner in which states accomplish all of the individual tasks — as well as how they weave their various systems together — defines their business delivery model. Individual states take a variety of approaches, and no design is right or wrong. In the end, the effectiveness of a state’s model will determine whether a state fully supports program integration or may be inadvertently undermining it.

Ideally, an integrated process that best uses the opportunities provided in the ACA would recreate a process that is seamless and holistic from the family’s perspective, and would use new technologies and deploy human resources as efficiently as possible. But realistically, it is difficult to start from scratch and completely revamp a system for delivering benefits that has been in place and is used by caseworkers throughout the state for decades. Even if a state decides that a wholesale change is necessary and feasible, careful thought and planning needs to go into how to transition to a new model.

Thus, the challenge for states will be to fit the pieces together in a way that builds on the strengths of their current structures while maximizing the possibilities for new investments and improvements. In some cases a state may need to make incremental changes — finding short-term solutions at the same time it makes longer-term improvements.

The key to developing more effective and efficient application, enrollment, and renewal processes is to shine a bright light on what’s currently in place, find the duplications and the bottlenecks, strip away policies and procedures that are neither required by federal law nor adding value, and then continually reassess the results and make refinements. Creating “process maps” of a state’s eligibility systems can be a very useful first step. These maps can be helpful for visualizing how a new process might work, where problems might occur and what the process will look like from both the family and the state staff perspectives. They also can be helpful in fostering dialogue within the state about which features of the current process are working and worth keeping and the greatest opportunities for change and improvement.

This endeavor requires openness to the possibility that many aspects of the state’s current process reflect state choices rather than federal rules, as well as the flexibility to re-imagine how the work could be done differently. And, because states’ processes may have redundant steps across programs, these efforts can illuminate opportunities for improved efficiencies through coordination.
**Potential Models for Coordinating Service Delivery**

States that want to streamline the delivery of multiple benefits have a variety of options for structuring their eligibility processes and IT systems. Entities that are responsible for making eligibility determinations for the different benefits programs must perform many of the same basic functions, such as processing applications, verifying information, providing customer support, issuing benefits, dealing with changes in circumstances, and processing renewals. Many tools and services can be valuable in supporting agencies as they accomplish these tasks, including IT eligibility and/or case management systems, rules engines, call centers, application processing centers, data imaging, and online self-service portals.

To the extent states share the tools, services, and staff among benefit programs in a way that links consumers to all benefits they qualify for, the state is implementing an integrated model for service delivery. However, the integrated model is not the only way to ensure that consumers can access a full range of benefits (see Figure 3).

States can maintain separate tools, services, and staff for individual benefit programs but connect consumers to all benefit programs using an interoperable model for service delivery. This model requires states to use electronic bridges that can securely and efficiently share consumer information.

States can also use a hybrid model for service delivery by sharing some tools, services, and staff while keeping other functions separate but electronically connected in a way that ensures access across benefits. For example, a state may choose to maintain one portal through which consumers can access all health and human services programs, but once entered, information for health programs is housed separately from information for human services programs. Alternatively, a state could house all health and human services data in one system, but have separate rules engines and business processes for those programs.

**Figure 3. States Have Multiple Options for Streamlining the Delivery of Multiple Benefits**

- **Interoperable System**
  - Different Systems
  - Different Rules Engines
  - Different Interfaces
  - Different Sets of Data, But Shared
  - Different Portals
  - Different Business Processes
  - Etc.

- **Hybrid System (example)**
  - Different Systems
  - One Rules Engine
  - One Set of Interfaces
  - Different Sets of Data, But Shared
  - One Portal
  - Different Business Processes
  - Etc.

- **Integrated System**
  - One System
  - One Rules Engine
  - One Set of Interfaces
  - One Set of Data
  - One Portal
  - One Shared Business Process
  - Etc.

Source: Jim Jones, Sellers Dorsey.
**Key Questions to Address in Designing a Streamlined Process**

Regardless of the model a state chooses, states need to address several key questions to ensure that processes are integrated across programs:

- For low-income families, how will states structure their major activities across programs, such as accepting applications, processing eligibility and benefits, and answering questions?

- Will low-income families have to undergo multiple application processes to receive a package of benefits? When a low-income family applies for one program, will they learn about other benefits for which they may be eligible? How will they get connected to those other programs?

- Who will have access to which programs’ application and verification systems? Will information in one program be used to verify eligibility or update information for another program?

- What functions will be centralized and what functions will be delivered in different local or regional offices around the state?

- When work is shared across tasks, or agencies, or programs, how will hand-off’s work and how will accountability be maintained?

- Will workers will be trained across multiple programs for all tasks, or will some tasks or some types of families be specialized?

- What roles will be filled by technology (online, telephone, etc.) and where will human involvement be crucial? How will families get their questions answered when technology alone is not sufficient?

- How will policy officials and managers know if the process is working?

**Implementing the Vision: About This Toolkit**

As states approach the question of how to implement the ACA’s coverage expansion, they face numerous questions about how to structure their processes and workforce, and how to use technology and other resources within federal rules. This toolkit is designed to help states sort through those choices. Specifically, it is intended to guide states in developing an eligibility system and process that meets the standards and requirements of the ACA, with a particular focus on ensuring that poor or near-poor families have a way to access the full package of available benefits. It raises issues and questions that states need to consider to ensure that these families’ experience with obtaining benefits is not only protected, but improved, as states modify and upgrade their systems.

Since Medicaid is the health coverage program for which most poor and near-poor families will qualify, this toolkit deals primarily with the Medicaid expansion. This toolkit does not, however, address all aspects of expanding Medicaid. For example, it does not touch upon the development of the benefit package that will be provided to the expansion population or the work that states will have to do to ensure a sufficient number of providers exist to serve all those who will newly enroll in Medicaid. Rather, it focuses on the key task of getting people enrolled into health coverage through an efficient and effective system that also connects them to the other benefits and services for which they qualify.
What Is Covered in the Toolkit?

Each section of this toolkit provides states with tools and suggestions for a guided process that can be used to review the current eligibility and enrollment service delivery model and compare the current model to the desired future model. The toolkit includes the following topics:

- **Eligibility Process.** This module will help states identify decisions about how their eligibility processes and structures will operate in 2014 and beyond. It is intended to facilitate discussion about how decisions related to the ACA will affect overall service delivery of benefits in a state.

- **Applications.** This module will help states take stock of how well their current applications perform in order to identify additional improvements that should be incorporated in the design of a new, ACA-compliant application. It will also help states identify questions that would need to be added to a Medicaid application to make it a multi-benefit application that can also be used for SNAP and other human services programs.

- **Verifications.** This module helps states identify opportunities for streamlining verification policies and processes across programs. It starts with a review of states’ current verification practices and walks through issues that states should consider in designing a verification process that minimizes the burden on families.

- **Renewals.** This module provides a framework for a guided process that state agencies can use to review how they currently conduct renewals, and design a new process to meet the ACA requirements.

- **Staff Readiness.** This module will help states assess their current staffing model, including taking an inventory of their current position descriptions, organizational structure, performance management system and staff training.

- **Project Management and Communications.** This module provides states with tools to kickoff their planning for ACA implementation. It walks through how to create an outline of a project plan, define team members’ roles and responsibilities, develop a project calendar, and create an outline of a communication plan.

It should be noted that this toolkit does not include a section on technology, which is a critical component of ACA implementation. This toolkit assumes that the development and procurement of the new systems that will support Medicaid eligibility and enrollment is likely well underway in many states. Instead the toolkit focuses on the other systems and processes that the technology will support.

To simplify the toolkit and the design of the exercises, this package mostly focuses on integrating the delivery of Medicaid and SNAP benefits — the two largest programs that states generally co-administer. But states are encouraged to consider and include other programs. This toolkit highlights Medicaid and SNAP because they present the most immediately available and highest-impact opportunities for many states: a great deal of participant overlap exists in these programs, and they serve the greatest number of low-income families. However, the full package of supports for low-income families is extensive, including child care assistance, cash assistance and other services offered through the Temporary Assistance for Needy Families (TANF) block grant, housing vouchers, Low Income Home Energy Assistance (LIHEAP), and the Earned Income Tax Credit, among others. States that want to include these other programs in their integration efforts should do so. Much of the issues for consideration raised in this toolkit are also applicable to the coordination of other benefit programs with Medicaid.
Who Needs to be Involved?

A successful planning process reaches the broadest group of stakeholders possible, including community organizations and clients. To complete most sections of this toolkit, it will be important to invite representatives from the following stakeholder groups:

- Policy officials from agency leadership and/or Governor’s staff
- Policy staff representing each program you plan to include (e.g., Medicaid, CHIP, SNAP, child care, TANF)
- Staff from the state’s health reform governing organization
- Operations experts, such as field supervisors and caseworkers
- IT analysts, particularly those knowledgeable around your planned IT changes under the ACA
- Human resources experts
- Outreach staff
- Communications experts
- Community-based organizations — especially those involved in outreach
- Advocates
- Clients

Individuals who represent these perspectives can be included from the beginning or brought in later in the process as appropriate. For each module of the toolkit, also consider including other people with more in-depth expertise on the particular topic that is being addressed. This toolkit is written for those with knowledge about program rules and processes and assumes the involvement of those who are engaged in ACA planning and have knowledge of ACA requirements.

What Types of Policy and Process Information Will Be Needed?

Each of the modules requires states to go through an assessment of current processes to identify what works and what doesn’t, changes that need to be made to comply with the ACA requirements, and improvements that will help states deliver benefits in a more streamlined fashion. Conducting these assessments requires information about federal and state requirements, as well as state-specific policies and processes that are currently in place. Table 1 lists some of these background materials.

In most instances, materials will be useful to completing several sections. For example, information on current worker processes and procedures for the benefit programs being reviewed will be useful for completing the applications, eligibility, verifications, and renewals sections. It is recommended that these materials be collected and distributed workgroup members in advance to maximize the productivity of workgroup discussions.
Using this Toolkit

This toolkit is intended to help ensure that state efforts to implement health reform factor in the delivery of other services provided to states’ lowest income households. The modules that follow are structured to guide states through the task of designing the various elements of a system for determining eligibility for Medicaid, SNAP, and other benefit programs. It is meant as a template to help guide state efforts. In many cases, states will need to tailor the exercises to meet their specific needs.

Each module provides context on the importance of the topic being addressed and how a state’s decision on the issue can impact a family’s ability to access multiple benefits. Each module also contains instructions on how to complete the section, including what materials and resources are needed, suggestions for information or data that should be gathered in advance, as well as estimates of the amount of time and effort that you might consider devoting to the process. While the topics covered in each of the sections are interrelated, each section is designed to stand on its own, so that states can complete only certain sections if they so choose.

Finally, the Center on Budget and Policy Priorities is available to work with state and local agencies on using this toolkit. We can help you design planning sessions that work for your state agency and have some availability for on-site facilitation. Please feel free to contact us to discuss this option.

Providing Feedback on This Toolkit

We value your feedback and would like to hear from you about ways that we can refine this toolkit and make it more useful. Tell us what you used, what you liked, what you didn’t like, and what could be improved. Please send comments and suggestions to Carolyn Jones at jones@cbpp.org.
Table 1. Background Materials Suggested to Support Planning Efforts

<table>
<thead>
<tr>
<th>Example Forms and Client Communications</th>
<th>Eligibility Process</th>
<th>Applications</th>
<th>Verifications</th>
<th>Renewals</th>
<th>Staffing Model and Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies of all current paper applications</td>
<td></td>
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<tr>
<td>Access to all current online applications</td>
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<tr>
<td>Copies of verification forms clients are required to submit (e.g., landlord form, employer statement, etc.)</td>
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<tr>
<td>Policies, Procedures, and Systems Manuals</td>
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<tr>
<td>Access to current worker processes and system(s) procedures for Medicaid, CHIP, SNAP, and other applicable programs</td>
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<tr>
<td>Access (electronically, if possible) to current administrative rules for Medicaid, CHIP, SNAP, and other applicable programs</td>
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<tr>
<td>Descriptions of current electronic interfaces and other forms of electronic verifications (e.g., The Work Number/TALX)</td>
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<tr>
<td>Access to new Medicaid rules for ACA</td>
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<td>Side-by-side comparison of Medicaid and SNAP federal rules (provided in Applications, Verifications and Renewals Appendices)</td>
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<td>High-level picture of new service delivery model</td>
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<td>Data and Reports</td>
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<td>Data on types of applications/renewal forms being submitted (online vs. paper)</td>
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<td>Data on most common types of paper verification submitted by clients</td>
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<td>Recent SNAP Quality Control data on errors related to verification, especially income</td>
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<td>Administrative data on Medicaid renewals</td>
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<td>Data on program overlap</td>
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<td>Human Resources and Project Documents</td>
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<td>Current position descriptions for eligibility and clerical staff</td>
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<td>Current organizational charts and staffing levels</td>
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<td>Current staffing performance reports and tools (e.g., annual review forms)</td>
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<td>Current training curriculum outline, training plan, and evaluation data</td>
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<td>Project Charter template (provided in Project Management and Communications Appendix)</td>
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<tr>
<td>Communications Plan template (provided in Project Management and Communications Appendix)</td>
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