

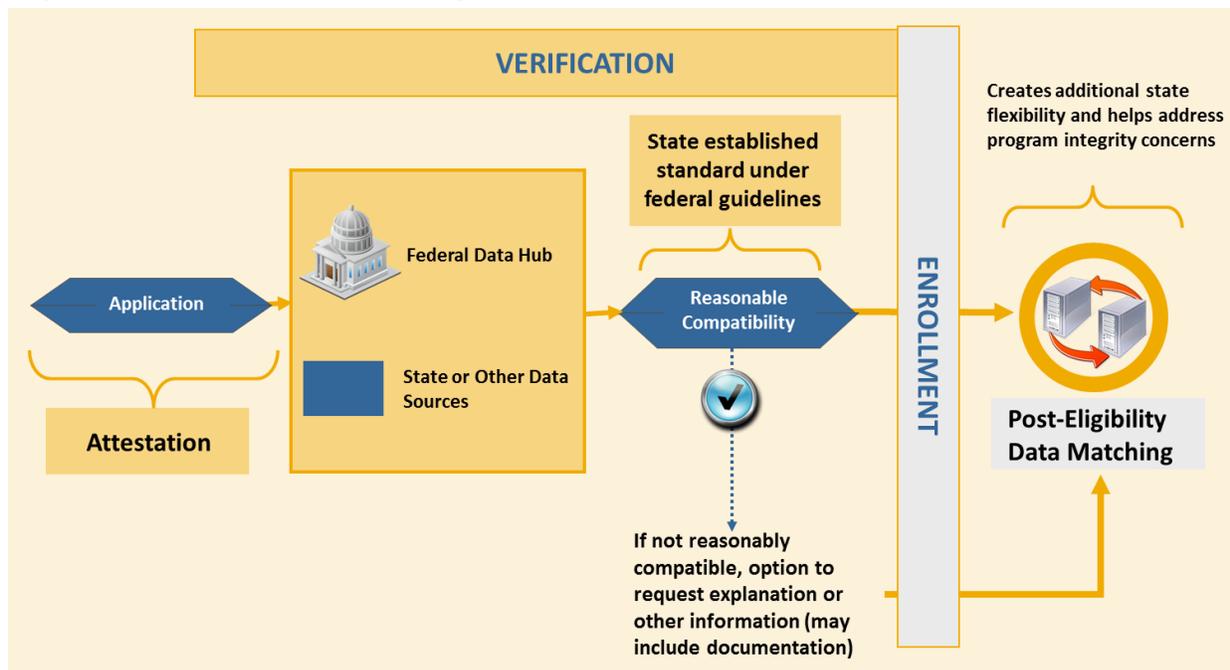
Simplified, Real-Time Verification Issue Brief

The Affordable Care Act (ACA) requires a coordinated and streamlined eligibility and enrollment process for all Insurance Affordability Programs (IAPs), including Medicaid, the Children’s Health Insurance Plan (CHIP), and advance premium tax credits/cost sharing reductions to purchase Qualified Health Plans (QHPs). Beginning in 2014, individuals will be able to apply for IAP coverage using a single, streamlined application which may be submitted online, by telephone, through the mail, or in person to the Medicaid/CHIP agency or new Health Insurance Exchanges (Exchange). Eligibility will be verified primarily through self-attestation and electronic data accessed through the federal data services hub (FDSH) and other state, federal and private data sources.^{i,ii} These requirements are intended to promote real time eligibility and enrollment in IAPs.

States have significant flexibility in determining their verification policies and procedures for Medicaid and CHIP, including determining the data sources on which to rely and the circumstances under which the information an applicant attests to will be considered reasonably compatible with the information obtained through electronic data sources and enrolled. Where the attestation is reasonably compatible with the data, no additional information may be requested from the applicant. Figure 1 below depicts the verification process.

Several state Medicaid/CHIP agencies have already implemented the type of streamlined and real time eligibility process contemplated by the ACA. The experience of these states provides useful models and “lessons learned” as all states look to implement the accessible and automated application, eligibility and enrollment process envisioned by the ACA.

Figure 1: Medicaid and CHIP Eligibility Verification Process



Oklahoma: Post-Enrollment Verification

In September 2010, the Oklahoma Health Care Authority (Oklahoma) launched an automated eligibility determination system through a new consumer web portal that allows for real-time eligibility determination and enrollment in the state’s Medicaid and CHIP programs. This new automated system has enabled Oklahoma to apply eligibility verification policies more consistently and accurately; improve application processing times; and reduce administrative costs. In short, not only has the process expedited coverage, it has resulted in lower eligibility error rates and state administrative savings.

To achieve real-time eligibility determination and enrollment, Oklahoma employs a post-enrollment verification process – meaning that the vast majority of the state’s Medicaid/CHIP beneficiaries are determined eligible based on their attested eligibility information – after which the state verifies key eligibility information through matching to electronic data sources.

At application, consumers authorize Oklahoma to verify eligibility information through data sources including government agencies, employers and other sources.

Oklahoma conducts electronic verification of income (and other eligibility factors) immediately following the initial, attestation-based determination and on a weekly basis thereafter. Oklahoma verifies attested income through the Oklahoma Employment Security Commission and employs a “reasonable compatibility” standard, accepting discrepancies of up to 5% between attested income and electronic income data sources. As reflected in Figure 2, Oklahoma’s post-eligibility verification data sources are called through a combination of real-time/automated processes and batch or manual processes.

Oklahoma estimates that just 2% of applicants are terminated for having income over the Medicaid/CHIP eligibility level after data matching.

Based on post-eligibility verification under current rules and using existing data sources, Oklahoma is able to validate approximately 50% of initial eligibility determinations without need for further information. For the remainder of beneficiaries whose eligibility cannot be satisfactorily validated through electronic data sources, Oklahoma requests documentation; pregnancyⁱⁱⁱ, citizenship (for those born outside of Oklahoma),

and income are the eligibility factors that most commonly require additional verification beyond electronic data sources. Oklahoma reports that the state is able to validate its initial eligibility determination for an additional 28% of beneficiaries based on documentation. Twenty-two percent of consumers who were determined eligible for coverage based on attestation are terminated from coverage for failure to submit documentation or submission of documents that lead to a determination of ineligibility. Program integrity audits using a random sampling are conducted by the Oklahoma Medicaid Agency as well as the state auditor’s office. Oklahoma’s eligibility determination error has remained relatively stable, at approximately 5%.

Figure 2: Oklahoma Post-Eligibility Data Sources

Eligibility Criteria	Data Source	Automated	Batch	Manual
Citizenship & Immigration Status	Department of Homeland Security			x
Employment & Unemployment Income	Oklahoma Employment Security Commission		x (weekly)	
Vital Records	Oklahoma State Department of Health		x (daily)	
Child Support	Office of Child Support Services		x (daily)	
Enrollment in Other State Medicaid Programs	PARIS	x		
Pregnancy	Providers			x

In terms of consumer communication regarding this process, once an applicant’s eligibility is determined based on his or her attestation and initial verifications are completed, Oklahoma sends a consumer notice regarding the Medicaid/CHIP eligibility decision for each household member, which may include disapproval, “unconditional” approval (meaning no additional information is required from the beneficiary) and “conditional” approval (meaning that an applicant is approved pending submission of documents needed to verify the eligibility decision). This letter alerts the consumer that benefits will be terminated if he or she fails to provide the requested documents within the appropriate timeframe conforming to federal requirements (e.g., 90 days for citizenship/immigration status document). Finally, the letter includes instructions to access the consumer website and call center as well as appeal rights. Oklahoma encourages consumers to utilize the call center as much as possible to resolve issues.

While processing 35,000 applications per month, Oklahoma averages only one fair hearing every two to three weeks.

Oregon: Document or Attest and Determine

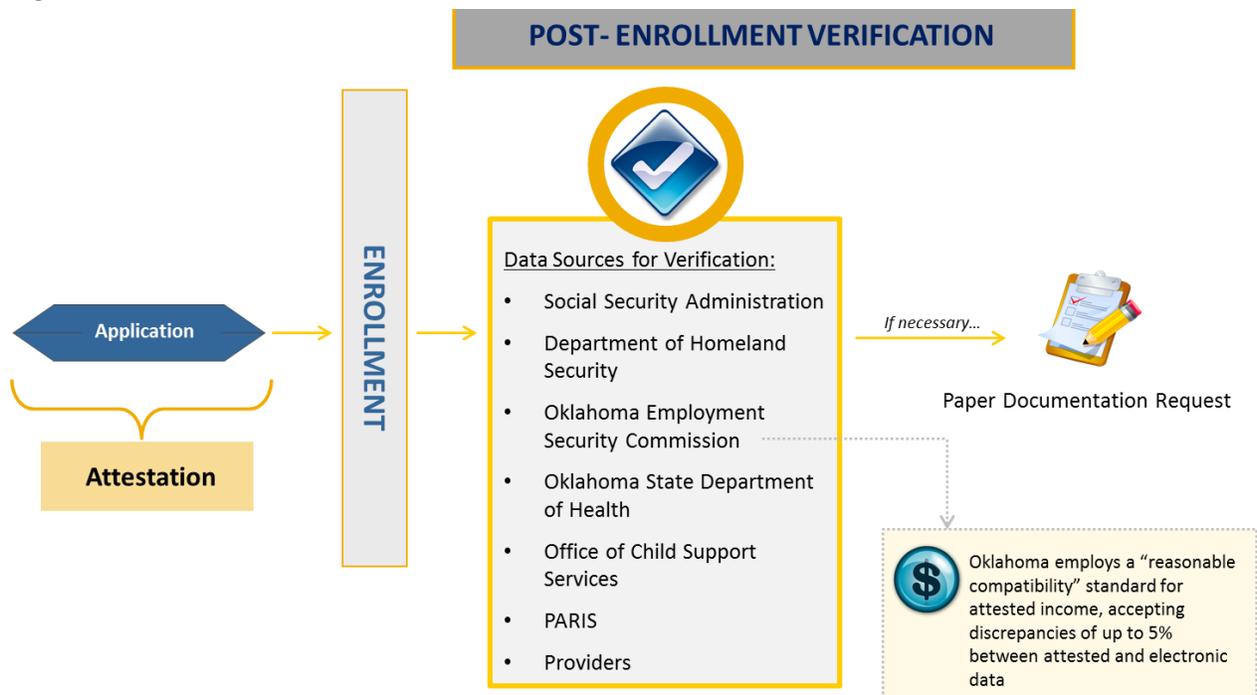
In preparation for 2014, Oregon has been working to upgrade its eligibility policies and build new IT systems that provide a seamless eligibility and enrollment experience for applicants across the Medicaid Agency (Oregon Health Authority), Exchange (Cover Oregon), and Human Services Agency (Department of Human Services). To achieve this streamlined process, Oregon employs a combination of attestation, documentation and pre- and post-eligibility verification, relying on the best information resources available in real-time to determine application eligibility for Medicaid and CHIP.

For example, if the date of application is November 30, 2012, the budget period could be November 2012, December 2012, or January 2013.

Oregon requests documentation of income (e.g., pay stubs) from all Medicaid/CHIP applicants, but lack of paper documentation is not a barrier to enrollment. The state routinely determines Medicaid/CHIP eligibility on the basis of attested income in cases where applicants do not provide income documents. The state also accepts applicants’ attestation of income with a reasonable explanation of the anticipated income changes, as contemplated under new ACA rules. Oregon also provides budget period

flexibility, such that an applicant’s income eligibility may be derived from any calendar month that includes one of the 45 days following application. This policy enables eligibility determination based on anticipated

Figure 3: Oklahoma’s Post-Enrollment Verification Process



income changes – in that the budget month could be the income anticipated in the next calendar month or months.

Oregon’s income verification process is manual; state workers check data sources including: Social Security Administration (via a web-based query system, SOLQ); the Oregon Secretary of State’s Business Registry; State Employment Department; and SNAP. Because access to some verification data sources is not real-time, Oregon accepts applicants’ attestation of eligibility information unless highly discrepant or conflicting information is uncovered through existing state systems. Oregon reports that internal audits have shown no increases in eligibility determination errors when it relies on the applicant’s self-attestation as compared to documents or verification data sources.

In the future, Oregon intends to automate as much of its verification process as possible and is exploring solutions to achieve real time verification on both a pre- post-eligibility basis. At application, Oregon intends to continue to accept an applicant’s attestation unless available electronic data sources contain highly discrepant or contradictory information. Oregon is contemplating gathering income data from various sources on a monthly basis to provide a more comprehensive view of income shifts.

Louisiana: Streamlined Renewal

Since 1998, Louisiana has a number of streamlined eligibility policies that contribute to seamless renewal and high rates of continuous enrollment in its Medicaid and CHIP programs, including: 12-months continuous eligibility, rolling or “off-cycle” renewals, no requirement for signature at renewal, and application of a “reasonable certainty” verification standard. The state has also implemented organizational changes to simplify and expedite eligibility re-determinations for Medicaid/CHIP beneficiaries. Leveraging these eligibility policies, available data sources and empowered eligibility workers, Louisiana has crafted several renewal strategies, described below, which enable the State to minimize beneficiary churning, achieve administrative efficiencies and cost savings, and maintain extremely low eligibility error rates.

Louisiana estimates that 1.5% of cases are closed at renewal and the state’s PERM rate is holding steady at less than 1%.

Reasonable Certainty Standard
At application, eligibility workers can approve applicants if they have “reasonable certainty” that attested information comports with database verification.
At renewal, income verification is not required unless declared income is within 25% of the Medicaid income eligibility limit and not supported by database information.

Administrative Renewal

Through data analysis, Louisiana identifies beneficiaries unlikely to be ineligible at renewal (e.g., a one-parent household with income below \$500, and without income changes in three years). The State targets its analysis to beneficiaries whose incomes may fluctuate, but are highly unlikely to exceed Medicaid or CHIP eligibility levels. For beneficiaries that meet these characteristics, Louisiana sends an automated letter prior to renewal advising them that their Medicaid benefits will continue and of their obligation to report changes in income or household size that may affect ongoing eligibility. The state renews beneficiaries automatically unless changes are reported.

Ex Parte

To the maximum extent possible, Louisiana also accesses available information from SNAP programs to support redetermination of Medicaid/CHIP eligibility. Eligibility workers will also manually check quarterly wage data to ensure that there are no discrepancies.

Express Lane

Louisiana employs Express Lane Eligibility (ELE) renewals for children, using SNAP eligibility information. Through an automated process, the state is able to validate SNAP eligibility for current Medicaid children. If validated, Medicaid eligibility is extended automatically.

Louisiana reports annual cost savings of approximately \$19 million through the use of administrative, ex parte, telephone and web renewals.

Telephone and Web Renewals

Where Louisiana is unable to complete a renewal using the above procedures, the state notifies the family of the need to renew and encourages them to pursue telephone or web renewals (beneficiaries are also notified of the option to complete paper forms). Louisiana reports that telephone and web-based renewals have reduced eligibility worker processing time and achieved administrative cost savings. For beneficiaries who do not contact an eligibility worker, the state conducts aggressive follow-up.

Conclusion

As States navigate the ACA's requirement for coordinated and streamlined eligibility and enrollment systems and real time verifications, Oklahoma, Oregon and Louisiana offer important "lessons learned". The ACA provides States significant flexibility in designing their Medicaid and CHIP verification policies and procedures. States now have the opportunity to use this flexibility and the best practices of their peers to establish streamlined eligibility and enrollment pathways that create administrative efficiencies, improve consumers' experience, and facilitate timely access to coverage and health care consistent with the ACA.

This issue brief was developed by Manatt Health Solutions for the Centers for Medicare & Medicaid Services. Manatt extends its appreciation to the States of Oklahoma, Oregon and Louisiana for their review and feedback.

ABOUT THE MAC COLLABORATIVES

This document was developed for the *Medicaid and CHIP Federally Facilitated Marketplace Eligibility and Enrollment Learning Collaborative*, one of a series of state-federal collaboratives being coordinated through the *Medicaid and CHIP Learning Collaboratives (MAC Collaboratives)*. The Centers for Medicare & Medicaid Services (CMS) established the *MAC Collaboratives* to achieve high-performing state health coverage programs, a goal that requires a robust working relationship between federal and state partners. The *MAC Collaboratives* are bringing together these partners to address common challenges and pursue innovations in Medicaid program design and operations as well as broader state health coverage efforts.

Visit the ***MAC Collaboratives State Toolbox on Medicaid.gov*** for products generated or used by the collaboratives, including technical assistance tools, state resources, and relevant background materials. The MAC Collaboratives are coordinated by Mathematica Policy Research, the Center for Health Care Strategies, and Manatt Health Solutions, with additional assistance from external experts and in close association with CMS. For more information, visit <http://www.Medicaid.gov>.

Endnotes

ⁱ ACA §1411, §1413(c); 42 CFR 435.945, 45 CFR 155.315, 155.320.

ⁱⁱ ACA §§ 1413(b)(1)(A) and 2201; 45 CFR 155.405; 42 CFR 435.907(a).

ⁱⁱⁱ Final Medicaid eligibility guidance provides that beginning in 2014, state Medicaid agencies must accept self-attestation of pregnancy unless the state has information that is not reasonably compatible with such attestation. 42 CFR 435.956(e).