

Coordinating Medicaid and the Exchange in New York

Danielle Holahan



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Foreword

The Health Insurance Exchange is a central concept of the Affordable Care Act (ACA), and, as the rubber hits the road with health care reform, decisionmakers are moving from concept to practice. Getting the Exchange to mesh with the many other moving parts in New York's health care system — particularly the Medicaid program — will require great attention to detail, without losing sight of the broader goals of reform.

With support from the New York State Health Foundation, the Fund is preparing a series of reports about health care reform and the Exchange. An earlier report by Peter Newell and Robert Carey examined the first set of governance and organizational choices states must make in designing their exchanges. This report examines in detail the organizational improvements necessary for improving and integrating current Medicaid processes for eligibility and enrollment, information technology, and communications with the new Exchange. It was prepared

by Danielle Holahan, former co-director of the Fund's Health Insurance Project, who recently moved into a leadership role with New York State's health care reform team, focusing on precisely these issues. Forthcoming reports in the series will consider the possible merging of the individual and small group markets, and what role the Exchange will play in defining products and plan participation in the commercial market.

The Fund's goal in preparing these reports is to help the State and stakeholders involved with the planning and implementation of the Exchange. As we grapple with the complex challenges of reform, we are reminded of the importance of the myriad decisions that promise to improve the way millions of New Yorkers obtain coverage.

JAMES R. TALLON, JR.
President
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Introduction

One of states' greatest challenges with the implementation of federal health reform will be to integrate Medicaid with their new Health Insurance Exchanges. Because Exchanges are expected to be the primary place individuals and small firms will go to seek health insurance coverage in 2014 and beyond, it is critically important that the enrollment experience works well for them. Several improvements will be necessary in meeting these challenges: streamlining Medicaid's historically complex eligibility and enrollment processes; managing transitions between sources of coverage as circumstances change; and significantly upgrading state information technology systems and communications with consumers, in order to provide superior customer service for all, no matter where they fall on the coverage continuum. New York has a strong foundation on which to build, as a long-time leader in eligibility and enrollment policies and, more recently, as a recognized leader in information technology for state Exchanges. States will receive significant federal aid in this work through formal guidance and technical and financial assistance to support this effort. The task is enormous, so states will need to tackle it piece by piece. But if the effort is great, so are the possible measures of success: a major step toward universal coverage, including an estimated 1.2 million or more newly insured New Yorkers; and improvement of the way millions more New Yorkers buy coverage — both those who will be newly subsidized and those who purchase coverage through the Exchange at full premium.

The Affordable Care Act (ACA) envisions access to affordable care for all Americans, a streamlined eligibility and enrollment process to obtain coverage, and seamless integration between Medicaid and the Exchange to ensure smooth transitions between sources of coverage as a person's circumstances change over time. To achieve the goal of seamlessness between Medicaid and the Exchange, there are five key areas

for coordination, each with multiple considerations: eligibility and enrollment; renewals and transitions; information systems; consumer communications; and challenges associated with aligning the plans, networks, and benefits offered. This paper explores the issues associated with these coordination challenges and identifies options for New York as it considers how to best approach the integration of coverage options along the continuum from fully subsidized public coverage to partially subsidized and unsubsidized private coverage offered in the Exchange. There will still be an insurance market outside of the Exchange, but discussion of coordination with the non-Exchange market is beyond the scope of this paper.

Eligibility and Enrollment

The ACA calls for a streamlined, user-friendly approach to health insurance enrollment and makes a significant effort to ensure the same consumer experience regardless of the type of coverage for which a person is eligible.¹ This system envisions that consumers will apply for coverage using a streamlined application form that will be the same for Medicaid and the Exchange. Consumers will be offered multiple access points — on the web, by phone, by mail, and in person — to apply for coverage and the option to start via one avenue and complete the process through another. Both Medicaid and the Exchange will screen for eligibility for all subsidized coverage options: Medicaid, Children's Health Insurance Program (CHIP), federally subsidized private coverage available in the Exchange, and a Basic Health Plan (BHP), if the state pursues this option. States will be required to coordinate eligibility determination and enrollment between Medicaid and the Exchange. In this vein, income eligibility for Medicaid and subsidized coverage in the Exchange will be determined using a modified adjusted gross income (MAGI) standard. (See accompanying box for a description of

¹ Patient Protection and Affordable Care Act, Sections 1413 and 2201; CMS/OCIO 2010.

this MAGI standard.) Lastly, states will be encouraged to verify eligibility factors through electronic matches with state and federal databases, instead of relying on paper documentation. The federal vision is that consumers with income from 0 to 400 percent of the federal poverty level (FPL) will have the same enrollment experience.²

Within the ACA's federal requirements for eligibility and enrollment, there are a number of areas of state discretion. First, New York may decide to use an application modeled on its current public program application, *Access New York*. If the state does so, it would need to eliminate unneeded questions and simplify it further to make it so straightforward that consumers can accurately complete it without assistance. Second, New York has the option of offering a BHP, a subsidized coverage option for people with income above the Medicaid level (138 percent of FPL) and below 200 percent of FPL, in lieu of federally subsidized coverage through the Exchange. Offering a BHP would have several effects. It would help smooth out differences in benefits and cost sharing between Medicaid and Exchange plans for individuals at this income level because of federal requirements for the BHP. However, there would still be benefit and cost sharing differences between BHP and Ex-

change products, so there would still be a transition — albeit less sharp — at 200 percent of FPL instead of 138 percent of FPL. Also, a BHP would add a third income eligibility cutoff, in addition to Medicaid at 138 percent of FPL and subsidies at 400 percent of FPL, and therefore create a third program requiring coordination.

A third significant decision facing the state pertains to the level of coordination versus integration between Medicaid and the Exchange. The ACA requires states to “coordinate” enrollment between these entities. This could mean merely collecting and sharing information needed for eligibility determinations, or it could mean full integration of eligibility and enrollment processes for Medicaid and subsidized coverage options in the Exchange. Either method would require real-time connections and coordination between entities to meet federal expectations.

The ACA permits the Exchange to contract with the state's Medicaid agency to conduct eligibility determinations for all subsidized coverage options, which would align with the full integration approach. Having integrated processes would not, however, preclude making certain exceptions. For example, some individuals applying for coverage through the Exchange will not be eligible for or interested in subsidies and therefore

Modified Adjusted Gross Income (MAGI). The ACA establishes a new, simplified income standard for Medicaid and Exchange eligibility determination. Beginning January 1, 2014, states will be required to use a modified adjusted gross income standard, or MAGI, to determine Medicaid eligibility for most nonelderly, non-disabled people. This income standard consists of adjusted gross income, as defined in the tax code, plus foreign income and tax-exempt interest. The new MAGI formula eliminates income disregard adjustments and therefore the need for applicants to report and provide paper verification of expenses as part of the Medicaid eligibility determination process.

Individuals who are elderly, disabled, medically needy, or eligible for Medicaid through other programs, such as cash assistance, will have their income calculated according to the traditional Medicaid formula, instead of the more streamlined MAGI test, and will continue to be subject to an asset test. In this paper we refer to “MAGI” and “non-MAGI” populations to distinguish between those whose income eligibility will be determined using the more streamlined income standard and those whose eligibility will continue to be determined using traditional methods.

HHS will define the methods for calculating family size and household income for the MAGI standard in guidance that is expected in the summer of 2011. (Patient Protection and Affordable Care Act, Section 2002, and Internal Revenue Code of 1986 36B(d)(2)).

² For a more detailed discussion of these issues, see Bachrach et al. 2011.

Hypothetical Exchange Enrollment Process for Individuals

Chart 1

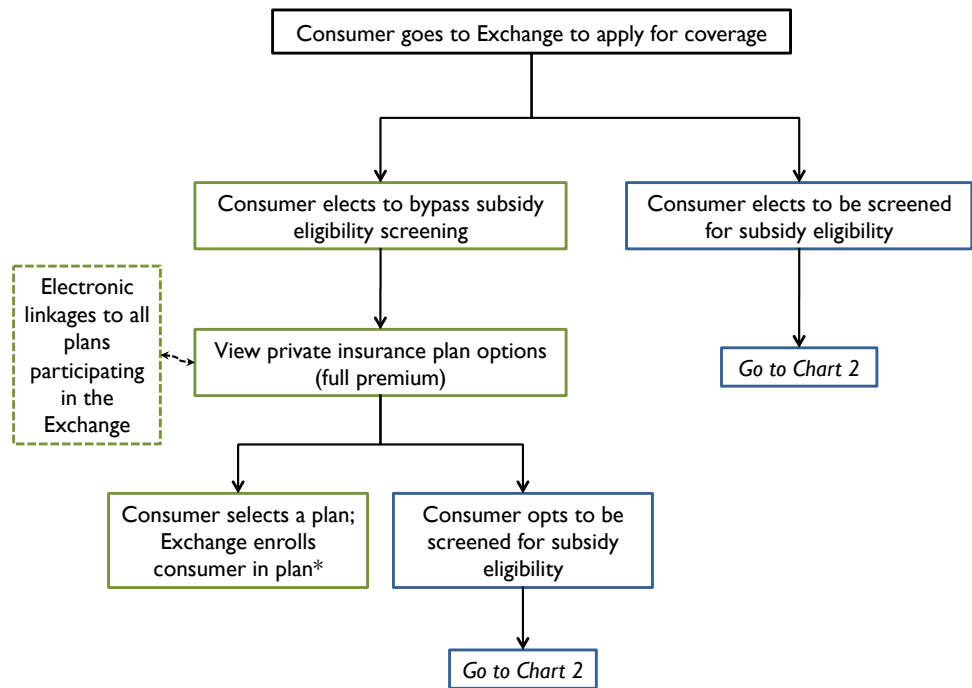


Chart 2

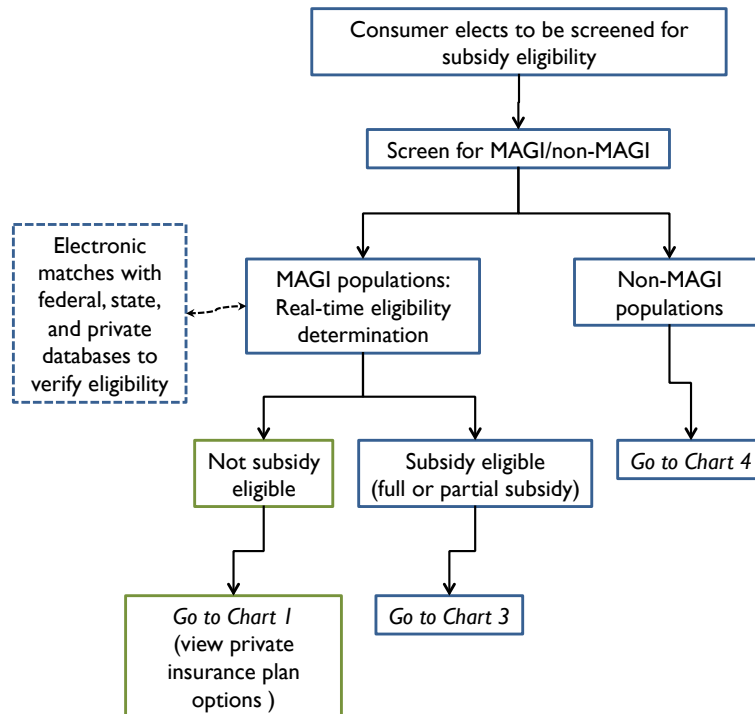


Chart Notes

Note that this is a high-level depiction of a hypothetical Exchange enrollment process. For ease of presentation, this intentionally leaves out other detailed steps (creating a user account, verifying identity, etc.) that will need to be incorporated at various stages.

*It remains to be determined whether the Exchange will enroll individuals in commercial plans and collect premiums or if the plans themselves will retain these functions. The State could decide that the Exchange will simply coordinate with commercial plans and transfer information to the plans to complete the enrollment. (Notes continue on next page.)

Hypothetical Exchange Enrollment Process for Individuals *(continued)*

Chart 3

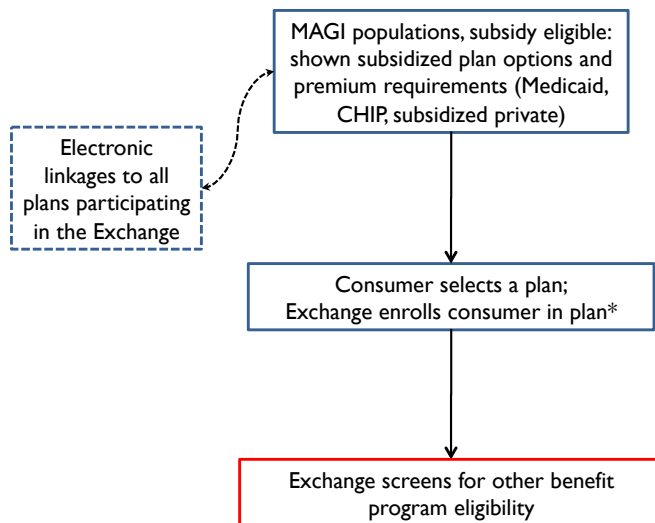


Chart 4

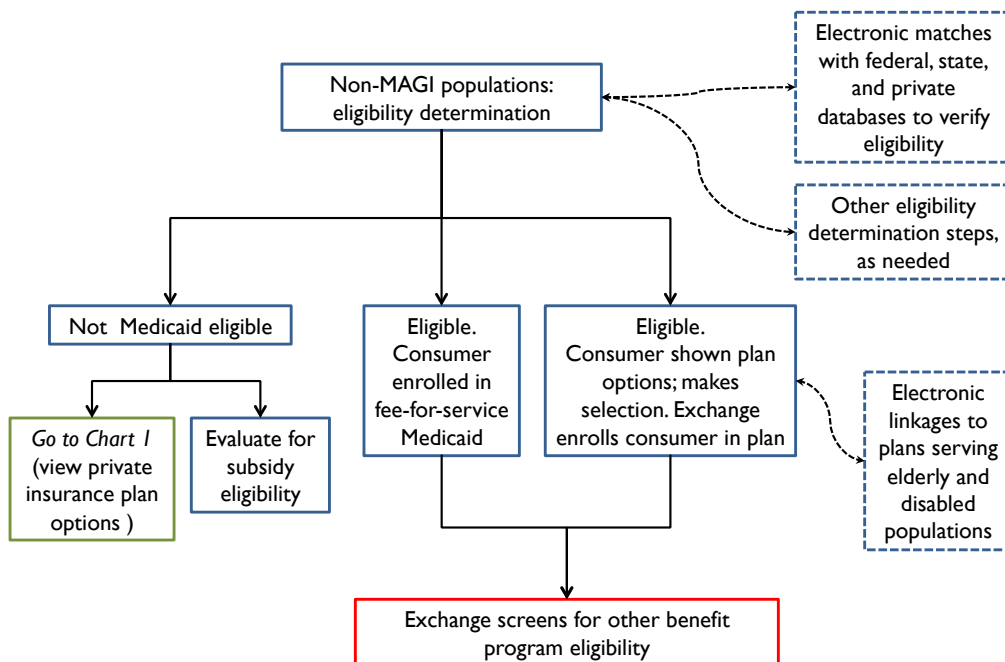


Chart Notes *(continued)*

The federal and state databases used to verify eligibility will include the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), Department of Vital Statistics, and State Wage File; private databases could include the Work Number, eFIND, or similar databases containing employer information.

With regard to enrollment of beneficiaries into FFS Medicaid, it is worth noting that the Medicaid Redesign Team provisions adopted in the 2011-12 budget envision enrolling additional populations in managed care over time (MRT Recommendation number 1458).

For those ineligible for all Exchange coverage options due to immigration status (i.e., undocumented noncitizens), the Exchange could provide information about hospital financial assistance programs and Emergency Medicaid, or test eligibility for these programs.

will not need or want to answer detailed eligibility screening questions. New York could consider an approach in which all individuals who apply for coverage through the Exchange are given the option of bypassing the income eligibility screening and going directly to plan choices and premium information. Others would be screened for eligibility for subsidies, and, depending upon what they are eligible for, given their choice of Medicaid or subsidized plans and associated premium requirements. Other considerations for these enrollment systems include the need to screen for eligibility for non-MAGI populations (e.g., elderly and disabled people) as well as the ability to screen for eligibility for other public benefit programs (e.g., Food Stamps, cash assistance). However, these provisions would likely be included in later stages of system design. (See accompanying charts.)

In its Exchange planning materials, New York has stated that it would prefer to maximize the uniformity in Medicaid and Exchange program rules.³ However, the state's ability to reform Medicaid's rules and integrate them with the private coverage options offered in the Exchange will require resolution of issues with four federal rules:

1. MAGI definition. States require guidance from the Centers for Medicare and Medicaid Services (CMS) on how Medicaid will apply the MAGI definition — specifically, what sources of income will “count” and how family size should be calculated in 2014 — because currently there are differences between Medicaid and federal income tax definitions of these factors.

2. Age of data. States require guidance or a waiver from CMS that will allow them to use

older tax data to meet Medicaid's point-in-time income requirement. This would enable states to simplify income verification strictly through tax data matching for Medicaid, as is expected for subsidy eligibility determination.

However, CMS has suggested that tax data will likely not suffice as the sole proof of income for Medicaid or subsidy purposes. This is because the IRS is expected to use current income data to set repayment penalties, so individuals who receive subsidized coverage based on old income data could potentially face significant penalties. States would need to consider alternative verification sources for more current income information. Alternatives include private verification sources, such as the Work Number or eFIND, which contain current wage and salary information compiled from national datasets of employers and are already used by certain states,⁴ and paper documentation (e.g., pay stubs) as a last resort.

3. Medical support provisions. States require guidance from the federal Department of Health and Human Services (HHS) or sponsorship of an amendment to the federal statute allowing states to apply the ACA's individual mandate in lieu of medical support enforcement provisions. The ACA mandates that all individuals obtain insurance for themselves and their dependents; medical support provisions require states to ask Medicaid applicants about absent parents/spouses who may be legally responsible to provide this support.

4. Federal Medical Assistance Percentage (FMAP) claims. States will need resolution of issues related to enhanced federal matching funds for newly eligible beneficiaries. Specifi-

³ New York State Comments to the Office of Consumer Information and Insurance Oversight, Department of Health and Human Services Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (HHS-OS-2010-0021-0001), submitted in October 2010, and New York State Department of Insurance Planning Grant Application.

⁴ Nationwide, over 2,000 employers participate in the Work Number, including 85 percent of the federal civilian workforce. The Work Number has over 190 million employment and income records on file, including 50 million current employment records. In New York, the Office of Temporary and Disability Assistance (OTDA) uses the Work Number in eligibility determinations and program integrity initiatives (<http://www.theworknumber.com/SocialServices/eSeminars/NewYork.asp>). For more detail on state experiences with verification sources, see Edwards et al. 2009.

cally, states will need alternatives to requiring determination of eligibility under both old and new eligibility rules for claiming enhanced federal matching funds.⁵ CMS has indicated its desire to ease this process for states to align with simplification goals.

Conversations between states and CMS on these topics are ongoing, and formal guidance on them is expected in the spring and summer of 2011.

Other Issues to Consider

There are three other enrollment-related issues to address when integrating new Exchange coverage options with existing programs and processes. First, New York will have to decide whether to continue certain programs for people with income above 138 percent of FPL or discontinue them in lieu of federally subsidized coverage in the Exchange. If the state decides to retain all programs, people with income of 139–400 percent of FPL could be found eligible for multiple programs. These include federal subsidies, Family Health Plus (FHP), CHIP, Medicaid spend-down, Medicaid buy-in for the working disabled, FHP premium assistance, COBRA, the AIDS Drug Assistance Program, and potentially a BHP. The state's eligibility system would need to screen for all programs and notify individuals of their options. Screening for other program eligibility could occur separately from the Medicaid and Exchange subsidy eligibility determination process, so long as consumers are notified of other potential program eligibility.

Second, it is also possible that different members of the same family will be eligible for different sources of coverage based on their age or immigration status, or that some family members could be ineligible for all Exchange options

due to their immigration status (e.g., undocumented noncitizens). Depending upon plan participation in various programs, different family members may be enrolled in different plans. New York will need to consider ways to best coordinate enrollment and renewal for families, including aligning coverage dates for all family members across plans to ease the renewal process. And, for those who are not eligible for any coverage through the Exchange, the Exchange could provide information about hospital financial assistance programs and Emergency Medicaid or test eligibility for them.

Third, the Exchange will also have to collect information on available employer-sponsored insurance (ESI) to determine eligibility for federal subsidies, and exemptions from the individual mandate. Individuals with access to ESI that meets the ACA's requirements for affordability and minimum essential benefits will not be eligible for federal subsidies toward coverage in the Exchange.⁶ New York will need to revise the processes it now uses to evaluate ESI in order to assess cost effectiveness for premium assistance and third-party liability.

Coverage Renewals and Transitions

Another critical aspect to ensuring seamless coverage is to have processes in place to collect updated eligibility information as individuals' circumstances change during the year or at annual renewal. A recent analysis of survey data projects that 50 percent of low-income adults are likely to experience a shift in eligibility from Medicaid to an Exchange plan or vice versa within a year (Sommers and Rosenbaum 2011). This level of fluctuation necessitates careful consideration of options for easing transitions or guaranteeing periods of eligibility regardless of changes in circumstances.

⁵ See Bachrach et al. 2011 for more detailed discussion of issues related to these federal rules.

⁶ Note that individuals with access to grandfathered ESI plans will also be ineligible for subsidized coverage in the Exchange even if this coverage is less comprehensive than the ACA's required minimum essential coverage, so long as the employer makes a sufficient contribution toward the coverage.

As outlined in the ACA, individuals who enroll in a qualified health plan through the Exchange will have a 12-month enrollment period, with a requirement to notify the Exchange if they have changes in circumstances (such as income or family size) during this period. This notification of changes is important because under the law, individuals with higher than expected incomes at year-end will have to repay excess advanced subsidies, up to a maximum between \$600 and the full excess amount, depending on their incomes.⁷ In addition, a change in eligibility could require a change in health plan, if different plans participate in Medicaid and subsidized private coverage.

New York's enrollment system will need to be set up to redetermine eligibility or adjust a subsidy level when an individual reports a change in circumstances. Furthermore, if a person's eligibility change requires a change in program (e.g., from subsidized private coverage to Medicaid or vice versa), the system will need to notify the individual of new plan options and facilitate enrollment into the plan of choice. The processes would be similar at annual renewal: redetermination of eligibility, assessment of plan options, and facilitated enrollment.

Due to differences in the timing of enrollment in Medicaid, CHIP, FHP, and subsidized private coverage, when individuals shift among these coverage options they would likely experience gaps in coverage. Traditionally, enrollment in Medicaid is effective at the point an eligibility determination is made, with three months of

retroactive coverage. In CHIP and FHP, enrollment is effective when an individual is enrolled in a plan, usually the first day of the month following application. For commercial coverage, enrollment is effective upon the plan's receipt of premium payment. Shifts between plans, therefore, would likely mean a gap in coverage. New York will want to consider options to eliminate such coverage gaps and ease transitions between programs, such as extending Medicaid until Exchange coverage is effective or vice versa.

New York could also consider pursuing guaranteed 12-month eligibility for individuals enrolled in subsidized private coverage through the Exchange. (In fact, the state indicated its interest in this policy in its comments to HHS in October 2010.⁸) This would align eligibility periods across Medicaid and subsidized private coverage because New York already guarantees 12-month continuous eligibility to children in Medicaid and plans to implement this provision for adults later in 2011.^{9,10} However, such a policy would require a waiver of the reporting requirements and associated penalties discussed above. Absent such a waiver, New York should consider aligning the reporting requirements between Medicaid and subsidized private coverage so that all MAGI populations follow the same reporting rules.

Information Systems

Modern information systems are a critical aspect of an accessible and consumer-friendly eligibility

⁷ These repayment amounts were increased in December 2010 legislation from a flat cap of \$250/individual to \$600–\$3,500, varying by income, for those with incomes below 500 percent of FPL (Section 208 of PL 111-309). More recent legislation, PL 112-9, signed into law by President Obama in April 2011, increased the maximum subsidy repayment amounts again, as follows: \$600 for individuals with incomes less than 200 percent of FPL, \$1,500 for individuals with incomes between 200 and 300 percent of FPL, and \$2,500 for individuals with incomes between 300 and 400 percent of FPL. PL 112-9 eliminated the cap on the maximum subsidy repayment amount for individuals with incomes of 400 percent of FPL and above.

⁸ See page 19 of "New York State Comments to the Office of Consumer Information and Insurance Oversight, Department of Health and Human Services Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (HHS-OS-2010-0021-0001)," submitted in October 2010.

⁹ New York's proposal to implement 12-month continuous eligibility for adults in Medicaid was approved by CMS in February 2010 and is expected to be implemented in 2011.

¹⁰ A related issue pertains to Medicaid recoveries, which would be expected to change with the implementation of continuous eligibility. Once the 12-month continuous eligibility policy is in place for adults, the state would presumably no longer pursue recoveries due to a change in eligibility during the 12-month period. Furthermore, the state assumption of Medicaid administration by 2016 will also allow for more uniformity in Medicaid recoveries, which have traditionally varied by county.

and enrollment process and necessary for ensuring seamless coordination between Medicaid and the Exchange. These systems must accommodate a high volume of applicants with varied technical skills and language abilities; interface with numerous federal, state, private, and employer databases to verify eligibility information; enable real-time eligibility determination; interface with participating health plan systems to enroll participants; store consumer information for re-use at renewal; process changes in enrollee circumstances to re-determine eligibility and change in health plan, if necessary; and notify applicants of eligibility, renewal, or other information. Because Medicaid and Exchange eligibility and enrollment systems must mesh so closely, and because many enrollees are expected to shift between sources of coverage as their circumstances change, the Medicaid and Exchange information systems must, at a minimum, be highly integrated. At most, they could share a single system and achieve the necessary coordination through a shared platform (CMS/OCIIO 2010).

HHS has outlined its high expectations for state Exchange and Medicaid information systems in a series of federal guidance and funding opportunity announcements:

- HHS Enrollment HIT Standards to facilitate enrollment and systems development (Sept 2010)
- HHS-OCIIO Cooperative Agreement to Support Innovative Exchange Information Technology Systems grant (Oct 2010)
- CMS-OCIIO Guidance for Exchange and Medicaid Information Technology Systems, “Version 1.0” (Nov 2010)

- CMS Notice of Proposed Rule Making, Federal Funding for Medicaid Eligibility Determination and Enrollment Activities (Nov 2010)
- HHS State Health Insurance Exchange Planning and Establishment Grant Announcements¹¹

This federal guidance requires systems that allow consumers to apply for and renew benefits online; provide superior consumer service, including real-time transactions; obtain electronic verification of eligibility from federal and state databases; allow third parties to assist consumers in enrolling and maintaining coverage; notify consumers of eligibility and enrollment; and provide seamless integration among health insurance options.¹² Each component in this series of guidance builds upon another with consistent statements of goals and expectations for this work. HHS has also indicated that the federal government will take the lead in developing several key systems components that will be available to all states. The first is a “verification hub” that would allow states to connect to federal databases, such as those of the IRS, DHS, and SSA, to verify eligibility information. The second is a “rules repository” that would contain MAGI eligibility rules written in a format enabling states to easily leverage them for their own systems. The intent of these federal initiatives is to centralize elements that will be uniform across all states so that states do not need to duplicate effort.

Furthermore, HHS has indicated that significant federal financial and technical support will be available to states for systems work, including through enhanced Medicaid federal matching

¹¹ HHS Enrollment HIT Standards Section 1561 to facilitate enrollment and systems development, September 2010: <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161>. HHS and OCIIO Cooperative Agreement to Support Innovative Exchange Information Technology Systems grant, October 29, 2010: <http://www.grants.gov/search/search.do?mode=VIEW&oppld=58605>. CMS and OCIIO Guidance for Exchange and Medicaid Information Technology Systems, Version 1.0 November 3, 2010: <https://www1.cms.gov/apps/docs/joint-IT-Guidance-11-3-10-FINAL.pdf>. CMS, Notice of Proposed Rule Making, Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, Federal Register 75(215): 68583-95, November 8, 2010: <http://www.gpo.gov/fdsys/pkg/FR-2010-11-08/pdf/2010-27971.pdf>. HHS State Health Insurance Exchange Planning and Establishment Grant announcements: <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html>.

¹² Section 1561 standards, Appendix A, and the November 3, 2010, Guidance for Exchange and Medicaid Information Technology Systems (Version 1.0).

funds and the Exchange “Early Innovator” funding. New York was one of seven states (or groups of states) awarded an “Early Innovator” grant in mid-February 2011, receiving an award of \$27.4 million over two years. (New York’s approach to this systems work is described in the next section.) HHS also intends to be closely involved with states in systems design work to ensure that the highest quality results are attained.¹³ This federal assistance offers New York an unprecedented opportunity to update its information systems to meet the requirements of the ACA.

Beyond these significant opportunities for state systems work, there are two longer-term systems challenges facing states. First, states will need to consider how non-MAGI populations (e.g., elderly and disabled) will be included in the upgraded system despite having different eligibility rules. In guidance to states, HHS has indicated its expectation that state Medicaid systems will handle more than MAGIs.¹⁴ Further, while enhanced FMAP is available through 2015 to design and build new Medicaid systems,¹⁵ New York may need to seek an extension of the enhanced FMAP beyond 2015 to allow time to incorporate non-MAGI populations into upgraded systems, which many anticipate will occur in later stages of design.

Second, Exchange eligibility systems are also expected to include a “consumer-mediated” approach that will allow for connection with other social services programs, such as cash assistance or Food Stamps. New York will need to consider the complexity and timing of integrating Medicaid with social services programs in addition to subsidized private coverage. Again, this is more likely to be incorporated in later stages of system design.

Consumer Communications

The ACA’s vision for a consumer-friendly enrollment process also requires New York to significantly upgrade its communications with diverse groups of consumers through multiple media. The Exchange will need to provide consumers with information in the following areas: available coverage options, eligibility requirements and enrollment procedures, notification of eligibility determination results, and consumer rights and responsibilities. This information will need to be provided in clear, simple language. Further, because states will be expected to communicate with consumers in a variety of modes, including paper, e-mail, and text message, consideration will be needed for these respective modes of communication. It will be important that all consumer communications from the Exchange — whether they pertain to Medicaid, subsidized or unsubsidized private coverage — be consistent in tone, format, terminology, and literacy level. Forthcoming federal guidance is expected to outline federal standards on these topics.

The ACA requires that, as of 2012, all insurance plans use a new health insurance disclosure form called the Summary of Benefits and Coverage to let consumers compare health insurance plans and understand the terms of their coverage. This form will be important for state Exchanges, which will provide information to consumers to help them understand their coverage options, and ultimately to facilitate the selection of and enrollment in coverage. HHS regulations on this form are expected in the coming months. Additionally, the National Association of Insurance Commissioners has drafted a prototype of the form that was consumer-tested

¹³ See, for example, HHS-OCIIO, “Cooperative Agreements to Support Innovative Exchange Information Technology Systems,” Funding Opportunity Announcement (CFDA 93.525), October 29, 2010.

¹⁴ See CMS/OCIIO 2010 and the HHS Exchange Establishment Grant application.

¹⁵ CMS, Notice of Proposed Rule Making, Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, Federal Register 75(215): 68583-95, November 8, 2010, <http://www.gpo.gov/fdsys/pkg/FR-2010-11-08/pdf/2010-27971.pdf> (accessed April 12, 2011).

by Consumers Union. These findings will likely inform the federal guidance and will be relevant to states, which will likely tailor the federal model form to meet their own specific needs (Quincy 2011).

In addition, Exchanges will also be required to use a rating system for plans to enable consumers to evaluate plan choices in a uniform way. Currently, the New York State Department of Insurance issues an annual *Consumer Guide for Health Insurance* that ranks insurance providers by specific criteria. Similarly, the Department of Health compiles consumer complaints and tracks HMO service and quality through its QARR and CAHPS reporting systems. The quality and consumer satisfaction information is made available to Medicaid-eligible individuals when they are choosing a plan. As much as possible, the plan rating system for New York's Exchange should use the same format and language and include the same information for Medicaid and private plans. HHS is expected to issue guidance on plan rating systems in the coming months.

A recent United Hospital Fund-led initiative examining New York's Medicaid client notices made a number of recommendations that are relevant for consumer communications from the Exchange: notices should use plain language and be written at an appropriate literacy level; use creative font and formatting, including graphics; be individualized as much as possible (e.g., refer to specific programs relevant to the consumer, be specific about missing information); and greatly simplify and streamline the fair hearing language. Background research for this project identified Pennsylvania's Medicaid notices as a potential model for New York. These notices use a creative layout with graphics and limit technical and legal language and citations, focusing instead on the information consumers need to understand to take appropriate action.

The findings from another recent initiative to

evaluate New York City's online Medicaid renewal tool, ACCESS NYC, are also relevant to the Exchange.¹⁶ Consumer testing of this tool found that consumers had particular difficulty with questions about income. Specifically, consumers were confused about how to classify various sources of income, how to report gross income, and how to report income if self-employed or with variable income. The evaluation also revealed the importance of literacy testing of all language on the form, including explanatory information that supplements the form (i.e., "help text"). For example, it was recommended that the security questions be reviewed for cultural competency to assess their relevance to Medicaid populations. Additionally, the researchers identified problems with the translation of the materials into other languages. Finally, many consumers noted the importance of the facilitated enrollers, whose help they received with the online renewal process. Thus, it was recommended that a help line be established for those who need real-time assistance to complete the process. While much emphasis is placed on electronic and paper communication with consumers, it is critically important to remember that many customers prefer live assistance, whether by phone or in person.

Finally, the Exchange will need processes in place to handle grievances and appeals and will need to coordinate them with Medicaid. Both individuals and employers will have appeal rights with the Exchange. Individuals can contest the determinations made by the Exchange regarding their eligibility to participate in the Exchange, their eligibility for subsidies, and denials of a request for an exemption from the individual mandate. Employers can appeal Exchange decisions if an employee is determined to be eligible for a subsidy because an employer does not offer minimum essential or affordable coverage. In New York, the Departments of Health and Insurance currently have separate grievance and appeals

¹⁶This work was done by the Coalition of New York State Public Health Plans and Children's Defense Fund of New York, with funding from the United Hospital Fund and New York Community Trust.

processes for public and commercial coverage (e.g., regarding access to care and coverage of emergency care) and Medicaid's Fair Hearing rights (available at DOH but not at SID) are the biggest difference between them. As much as possible, New York should seek to align and coordinate the grievance and appeals processes for Medicaid and private coverage.¹⁷

Other Challenges to Integration

Even if the aforementioned areas are well-coordinated between Medicaid and the Exchange, differences in participating plans, associated provider networks, and benefits offered between Medicaid and subsidized commercial coverage participating would present challenges as people move between these sources of coverage. In New York, only six of eighteen HMOs offer commercial coverage and participate in all public programs, and three-quarters of public program enrollees are served by eleven prepaid health services plans that do not offer commercial coverage (Newell, Baumgarten, and Heffernan 2010).¹⁸ Left unchanged, this would necessitate plan changes as individuals' eligibility fluctuates. Furthermore, there are currently differences between networks and benefits in public and commercial plans, which would necessitate changing providers and adjusting to a new benefit package and cost-sharing obligations.¹⁹ The ACA requirement that qualified health plans in the Exchange include "essential community providers" in their networks could help with the alignment between

Medicaid and commercial networks. Federal guidance defining essential community providers is expected in the coming months.

There are two key challenges to continuity of coverage and provider access across Medicaid, CHIP, and subsidized coverage options. The first relates to the churning discussed above associated with fluctuations in income and eligibility for coverage and thus the potential to cycle between different plans. The second relates to "mixed families," or families in which different members are eligible for different coverage, which could occur because of the different eligibility cutoffs for Medicaid (138 percent of FPL), FHP (150 percent of FPL), CHIP, and federal subsidies (both 400 percent of FPL).

To achieve continuity of plans along the continuum of coverage options, states may be permitted to require that all plans participating in the Exchange offer all products: Medicaid, CHIP, subsidized and unsubsidized private coverage.²⁰ This would mitigate disruptions in care when a person's circumstances change. However, states should carefully consider such a requirement because it would be a significant and complicated change. Absent a requirement, New York should consider ways to incentivize plans to participate in all products, including setting up the Exchange so that it is attractive for plans to participate in all programs. States will need to consider these incentives carefully so plans are not dissuaded from participating in the Exchange; robust plan participation is critical to achieving a high volume of enrollment in the Exchange, which in turn can help the Exchange achieve efficiencies and minimize adverse selec-

¹⁷ One approach would be an integrated state appeals process for all subsidy eligibility determinations, modeled on the Medicaid Fair Hearing process but administered by a state agency independent from Medicaid. (Personal communication with Trilby deJung, Empire Justice Center, and "Designing an appeal process in conformity with Section 1411(f)(c)," the Tennessee Justice Center, National Health Law Program, and Center for Medicare Advocacy, 2011.)

¹⁸ Note that under current New York State law, PHSPs cannot have more than 10 percent enrollment in commercial products. HealthFirst is the only PHSP with a commercial HMO license.

¹⁹ See Newell and Baumgarten 2011 for detail about plan participation in Medicaid and commercial insurance products.

²⁰ PPACA Section 1555 pertains to potential limits of federal/state authority to require such plan participation in federal health insurance programs.

tion. Plans will also be incentivized to participate in multiple programs because they will understand the degree to which their enrollees' incomes fluctuate and will not want to lose enrollees to this eligibility churning.

New York's Starting Point and Early Vision for 2014

In preparing for reform, New York will need to assess its existing capabilities and determine what can be leveraged, which functions can be consolidated, and what the State will need to build or buy in order to comply with the ACA's requirements. Chief among the State's relevant assets are its Enrollment Center, scheduled for launch in 2011; the Medicaid Enterprise infrastructure;²¹ a strong foundation of eligibility and enrollment policies; and the authority to centralize Medicaid administration. Furthermore, New York has two important projects underway pertaining to its information systems: the Early Innovator grant for Exchange systems development, and an analysis of its information technology systems and needs being conducted by outside consultants.

Enrollment Center/HEART

The Healthcare Eligibility Assessment and Renewal Tool (HEART) is an automated eligibility decision tool that will be used by Enrollment Center staff to assist eligible New Yorkers with phone and mail renewal beginning in June 2011. This tool will initially interface with the Department of Health's upstate eligibility system and is referred to as a "rules engine," currently programmed with approximately 10,000 Medicaid business rules. The tool is designed for use by Enrollment Center staff to facilitate the renewal process, allowing the worker to confirm and ver-

ify certain information available in real time (e.g., while on the phone with a consumer), and helping standardize the eligibility determination process. Although HEART is currently programmed to apply existing Medicaid eligibility rules, it was designed to accommodate new rules and program changes as they occur.

Eligibility and Enrollment Policies

New York has a strong history of implementing policies to streamline public program eligibility and enrollment. These include elimination of the Medicaid asset test, 12-month continuous eligibility for children and adults (in 2011), and data matching with the Social Security Administration to verify citizenship status and identity. For 2014, the state will need to build upon this foundation to further simplify enrollment, but has a strong starting point. For all groups except a small percentage of childless adults, New York's public program eligibility levels already meet or exceed the ACA's requirements for 2014.

Centralized Medicaid Administration

New York's 2010-11 budget mandated the creation and implementation of a five-year plan for the state to assume all Medicaid administration. Centralized administration of Medicaid will help the State consolidate functions, eliminate inconsistencies in program administration, and significantly ease coordination with the Exchange. The State's November 2010 report on Medicaid administration contained a recommended phase-in plan that included the launch of the statewide Enrollment Center, with consolidation of consumer help lines and telephone renewal in 2011, and state assumption of responsibility for eligibility determinations for non-elderly and nondisabled people under federal MAGI rules, concurrent with the implementation of federal health reform.²²

²¹ "Medicaid Enterprise" refers to Medicaid's information technology infrastructure, which includes state Medicaid operations and interfaces between state Medicaid agencies and stakeholders.

²² New York State Department of Health, "New York State Medicaid Administration, November 2010 Report": http://www.health.state.ny.us/health_care/docs/2010-11_medicaid_admin_report.pdf.

Early Innovator Exchange IT Initiative

In its Early Innovator proposal, New York discussed leveraging existing Medicaid Enterprise assets (including the data center and the technical architecture of its medication management pilot) to support a modern, consumer-friendly Health Benefit Exchange.²³ New York also plans to integrate HEART logic as part of the larger solution. In February 2011, New York was awarded a two-year \$27.4 million Early Innovator grant to carry out this work. HHS is expected to provide significant technical support to help innovator states meet their goals, and to ensure that this federal money is well spent; as the program name suggests, these states are expected to lead the way, serving as models for other states updating their own information systems.

Information Technology Gap Analysis

As part of New York's work to prepare for health reform, it is working with Social Interest Solutions (SIS) and The Lewin Group, with funding from the New York State Health Foundation, to assess its eligibility and enrollment systems capacity and needs. Through this gap analysis, SIS will inventory existing systems — in both the public and private sectors throughout the state — to assess the state's existing information technology (IT) assets, determine what can be leveraged, and identify what else is needed to meet the ACA requirements. SIS will assess the systems capabilities for potential use in New York's Exchange and The Lewin Group will gather stakeholder input from government, business, consumer, health plan, provider, and policy experts on the challenges and opportunities provided by the ACA's systems requirements. The findings and recommendations from this analysis are expected in May 2011.

New York's Vision

As outlined in several of the State's planning documents, New York anticipates a vastly simplified enrollment system built on modern information system standards and protocols.²⁴ This will include a consumer-friendly front end and a rules engine that will enable a more automated determination of eligibility for Exchange, Medicaid, and CHIP, as part of a new eligibility and enrollment system. At the front end, it is envisioned that a consumer will supply minimal eligibility information, and will be able to have his or her eligibility determined easily and with significantly less reliance on paper. It is also contemplated that a consumer, with identity and privacy protections, will be able to view eligibility information the state has acquired through data matches with state, federal, and private databases, and have the ability to update or correct personal information. The rules engine will take the information and make a determination of eligibility. And the consumer will be able to select and enroll in an appropriate health insurance option, as well as switch from one option to another.

New York plans to leverage its investments and work on health information technology, and its work on HEART will be an important asset in terms of the work required to establish a new Health Insurance Exchange in New York that is anticipated to have more robust linkages to federal and potentially other verification sources, and to be using a new federal data hub. Depending upon emerging rules and construction of the federal hub, the state might also want to explore other verification sources, including the Work Number and eFIND, which contain current wage and salary information compiled from na-

²³ The New York State Medicaid program claims processing system, eMedNY, was developed in 2005. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients. eMedNY offers several technical and architectural features, facilitating the adjudication and payment of claims and providing support for its users. Computer Sciences Corporation (CSC) is the eMedNY contractor and is responsible for its operation: <http://www.emedny.org/index.aspx>. The MMIS contract is currently out for re-bid.

²⁴ New York's application for the Exchange planning grant (http://www.healthcarereform.ny.gov/exchange_planning_grant/docs/narrative.pdf), comments to the Notice of Proposed Rulemaking submitted in October 2010 (http://healthcarereform.ny.gov/docs/nys_comments_title_i_ppaca.pdf), and conversations with senior staff in the Office of Health Insurance Programs, New York State Department of Health.

Key Timelines

February 2011	Early Innovator IT grants awarded
March 2011	States conduct IT gap analysis of existing systems; states begin developing requirements for integrating or interfacing Exchange and state subsidy programs for eligibility, enrollment, coordination of applications, notices, appeals, and managing transitions
May 2011	New York's IT gap analysis to be completed
June 2011	Federal guidance on Exchange infrastructure expected; states execute agreement with Medicaid agency that includes: roles and responsibilities for eligibility determination, verification, and enrollment; strategies for compliance with "no wrong door" policy; New York's Enrollment Center launches, with consolidated call center and telephone renewal
Summer 2011	Federal guidance on MAGI and Medicaid income and eligibility rules expected
October 2011	Detailed design review of Exchange IT systems (Early Innovator states)
December 2011	States must have developed Exchange governance model and finalized IT and integration architecture
January 2012	States must begin systems development for eligibility determination purposes (for states that are not Early Innovator states)
June 2012	States must have Exchange governance structure in place and board appointed
October 2012	Operational readiness of Exchange IT systems (Early Innovator states)
December 2012	States must complete eligibility determination/enrollment system development and prepare for user testing
January 2013	HHS certification of state Exchanges
June 2013	States can begin using HHS model applications and notices to support eligibility and enrollment; states can begin conducting eligibility determination and enrollment into qualified health plans
July 2013	HHS expectation for States to begin accepting applications through their Exchanges
January 2014	Implementation of ACA coverage provisions: Medicaid expansion, federal subsidies, Exchange, individual mandate; New York State assumption of Medicaid administration of MAGI population to coincide with health reform implementation

The federal timeline is outlined in Appendix B of HHS OCIO "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges," January 20, 2011; New York State-specific information is based on conversations with state officials; information about the IT gap analysis is from the New York State Health Foundation.

Other State Examples

Wisconsin

Wisconsin has been a leader in developing eligibility and enrollment systems and is a potential model for New York. Wisconsin offers a one-stop self-service tool, called “ACCESS,” with which consumers can apply for several social programs, including BadgerCare Plus and FoodShare. ACCESS includes an eligibility assessment, an online application, and the ability to renew benefits and report changes in eligibility status; soon it will also perform a needs assessment to assist with plan selection. Simplified eligibility rules, including a gross income test, are virtually identical for anyone under 200 percent of FPL and have greatly eased the eligibility process. However, certain applications may require follow-up via telephone. Documentation requirements (submission by fax, by mail, or in person) and the federal requirement that public employees actively verify eligibility are hurdles to further simplification and efficiency. Despite these modest limitations, ACCESS has become the dominant application method among family coverage applicants in Wisconsin. More than half of these BadgerCare Plus applicants used ACCESS between January 2008 and November 2009, whether they were at or above 150 percent of FPL (85 percent using ACCESS) or below 150 percent of FPL (56 percent), and whether their primary language was English (63 percent) or another language (51 percent) (Leininger et al. 2011). Wisconsin intends to use ACCESS as the portal to its Exchange, and it currently has a prototype of its Exchange system available online at <http://exchange.wisconsin.gov>.

ACCESS, the front-end program, is integrated with Wisconsin’s eligibility system, “CARES,” and its Medicaid management information system. CARES exchanges data with state and federal databases, including: IRS income and asset information; state wage, unemployment compensation, and new hire data; SSA information on disability payments, SSI, and Medicare information; and child support enforcement data (paid and received). While exchanges of SSA and certain state data currently automatically update Wisconsin’s eligibility system or alert workers to changes, most of its data exchange sources are verification tools that require action on the part of state workers. However, the state’s new “integrated State of Wisconsin Acquisition of Proof” (iSWAP) technology, scheduled for rollout in November 2011, will automatically update information in the eligibility system using SSA, unemployment, child support, earned income (via the Work Number), vital statistics, and other third-party data. It will use these data to determine eligibility at the point of enrollment, renewal, or when changes occur. The technology will also use state wage data to confirm wage information provided by the applicant or beneficiary. The iSWAP program will allow largely automated, real-time eligibility determinations with very little need for interaction between state workers and consumers, putting verification of third-party information in the hands of the consumers rather than the workers. (Kaiser 2010; Jones 2011.)

Pennsylvania

Pennsylvania also has innovative enrollment tools that could serve as models for New York. Pennsylvania’s online application system, COMPASS, bridges its Medicaid, CHIP, and state-funded program for low-income adults, and also allows individuals to apply for cash assistance, the Supplemental Nutrition Assistance Program, and other assistance programs. Pennsylvania’s “Healthcare Handshake” automatically transfers data between the Department of Public Welfare (Pennsylvania’s Medicaid agency) and the Insurance Department. This transfer occurs at the point of application, allowing a fully populated application to be submitted to other programs if an individual is found ineligible for one. In addition, the data transfer occurs if an individual loses eligibility for one public program but may be eligible for another, minimizing preventable gaps in coverage.

One current limitation of the COMPASS system is that applications require paper documentation to satisfy several eligibility elements, even where verifiable data are available electronically. (Artiga et al. 2010; correspondence to CMS re: File Code OCIO-9989-NC. http://www.childrepartnership.org/AM/Template.cfm?Section=Law_and_Guidance&Template=/CM/Content-Display.cfm&ContentID=15118.)

tional employer databases. Some states have experience using these databases, either in lieu of documents at renewal (Louisiana) or as a supplementary verification source (Utah, Wisconsin). States will need to consider the costs associated with using private verification sources and could consider coordinating with other states for a group purchase discount or asking HHS to do so on behalf of all states.

Eligibility and enrollment system needs will also be addressed in the IT gap analysis described above. This analysis will assess New York's IT capabilities and needs, and the Early Innovator grant will give New York significant support to develop and build its IT platform. Less is known about the State's vision for consumer communications and potential integration of plans, networks, and benefits across programs in the Exchange; however, the key issues and choices are outlined above.

Conclusion

Meeting the ACA's vision that all Americans have access to affordable care will require successful implementation of a Health Insurance Exchange and seamless coordination between Medicaid and the Exchange so eligible people can easily enroll in and retain coverage. Such seamless integration will require careful attention to five key areas: eligibility and enrollment, renewals and transitions, information systems, consumer communications, and challenges associated with aligning the plans, networks, and benefits offered. Under this vision, consumers with income from 0 to 400 percent of FPL are expected to have the same "first-class" enrollment experience. A significant level of income fluctuation is expected, so states will need to de-

velop ways to ease transitions between programs and eliminate any gaps in coverage when people shift between sources of coverage. Information technology will be a key component to ensuring seamless coordination between Medicaid and the Exchange and to implementing an accessible, consumer-friendly eligibility and enrollment process. New York will need to significantly upgrade its communications with diverse groups of consumers through multiple media, paying particular attention to literacy levels. Finally, the state will need to consider ways to incentivize plans to participate in all programs offered in the Exchange to minimize the need for individuals to change plans or providers as they transition between programs when their circumstances change.

The complexity of these tasks could easily overwhelm those charged with implementing them, so it will be important for states to address them piece by piece. New York has a strong starting point in this work and will receive substantial financial and technical support from the federal government. The importance of success should not be understated: meeting the ACA's coverage goals would mean an additional 1.2 million or more insured New Yorkers, and taking full advantage of this opportunity to implement the Exchange will improve the way millions of other New Yorkers get their coverage.

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