



Lessons from New York: Building a Better Medicaid Eligibility and Enrollment System for Duals

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Prepared by:
Doug Goggin-Callahan

Medicare Rights Center



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Contents

INTRODUCTION	1
MEDICAID EXPANSION AND IMPROVEMENTS UNDER THE AFFORDABLE CARE ACT	4
LEFT BEHIND: NON-MAGI MEDICAID BENEFICIARIES	7
MOVING TOWARD A SINGLE SYSTEM IN NEW YORK STATE AND LESSONS FOR OTHER STATES	9
THE ROAD AHEAD	16

Introduction

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 set state Medicaid programs on a course for dramatic expansion and improvement. Nationally, Medicaid eligibility was significantly expanded, as the income eligibility ceiling was raised and categorical eligibility was expanded to cover childless adults.¹ These provisions could provide health insurance to more than 15.1 million adults in the United States, or nearly one-third of the people in this country who are currently uninsured. Not only does this expansion offer the promise of health care for more Americans, it also offers cost savings to states, potentially reducing net spending on state and local government safety net programs for the uninsured by \$101 billion between 2014 and 2019.²

Another important provision of the ACA's Medicaid expansions is the requirement that states build new eligibility systems. These new eligibility systems will use data sharing, drawing from various state and Federal data records, to populate and verify information on Medicaid applications and recertifications. If well executed, this provision will provide states with the ability to make real-time eligibility and enrollment determinations, and mitigate the need for applicants to provide in-person paperwork to verify information provided to the state on their applications.

The promise for Medicaid beneficiaries is a streamlined, quicker, and less onerous application process. The promise for states is a system that relies on real-time electronic information exchange, such as tax filings, to verify applicant income, rather than on paper documentation like paycheck stubs and bank statements. The new system would help states avoid expending resources on manually following up with applicants for additional information that could be accessed from state or Federal sources. Thus the new system would protect eligible applicants from being denied benefits simply because the applicant did not supply supporting documentation, to which the state already has or could have access.

However, these major changes to ease access and enrollment are reserved for only a segment of Medicaid recipients, and the ACA does not mandate that states extend the eligibility and enrollment improvements to all Medicaid-eligible populations. More specifically, for non-disabled

¹ United Federation of Independent Business v. Sebelius, 576 U.S. ____ (2012) (Although the Federal government cannot compel states to expand their Medicaid programs at the peril of losing all Federal Medicaid funding, states may—and New York will—enact the Medicaid expansion changes outlined in the ACA).

² Angeles, January, *How Health Reform's Medicaid Expansion will Affect State Budgets*, The Center for Budget and Policy Priorities (2012).

Introduction *(continued)*

Medicaid beneficiaries between the ages of 19 and 65, beginning in 2014, states will be required to use a more simplified income eligibility calculation—modified adjusted gross income (MAGI).³

For this Medicaid population, referenced in this brief as the MAGI population, the income eligibility threshold, with a 5% income disregard, will effectively expand to 138% of the Federal Poverty Level (FPL), or approximately \$32,000 of annual income for a family of four, and the Medicaid asset test will be eliminated. However, these improvements, including the new income eligibility thresholds, will not be used for people with Medicare (i.e., non-MAGIs).⁴

Although the ACA does not command states to create an improved enrollment system that includes both MAGI and non-MAGI Medicaid beneficiaries, states can and should. States that do not could end up with two enrollment systems: a streamlined system that relies on data sharing for MAGI beneficiaries, and a more antiquated system for non-MAGI beneficiaries. This bifurcated Medicaid program would not only put non-MAGI beneficiaries at a disadvantage, it would also expend state dollars on operating and maintaining two separate systems.

Despite the negative implications for both beneficiaries and states, states may not have identified this important issue. Moreover, some states may erroneously believe that the ACA prohibits the creation of a single enrollment system. In fact, enhanced Federal Medical Assistance Percentage (FMAP) rates are available to states to build a single system.

Working closely with state and Federal partners, and with the support of the New York State Health Foundation (NYSHealth), the Medicare Rights Center (Medicare Rights) secured New York State's commitment to build one Medicaid eligibility and enrollment system that includes both MAGI and non-MAGI populations, and to adopt an asset verification system (AVS) that would help streamline the current Medicaid application process for non-MAGI beneficiaries before 2014. Moreover, in part because of Medicare Rights' advocacy efforts, Federal guidance now firmly moves all states in the direction of a single Medicaid program and prohibits states from using Federal funds to maintain two enrollment systems.

³ P.L. 111-148 § 2002.

⁴ For the purpose of this paper, non-MAGI beneficiaries will refer to individuals who are dually eligible for Medicare and Medicaid, including those eligible for Medicare and a Medicare Savings Program (MSP). However, non-MAGIs also include: (1) individuals who are eligible for Medicaid through another Federal or state assistance program (e.g., foster care children and individuals receiving SSI), (2) the medically needy, and (3) determinations of eligibility for Medicaid long-term care services.

Introduction *(continued)*

Medicare Rights has developed a set of recommendations to assist other states in building a single Medicaid enrollment system by 2014. These recommendations include:

- Create a single, modernized enrollment system capable of processing applications for all Medicaid beneficiaries, including non-MAGIs.
- Align and simplify the application and renewal processes among MAGI and non-MAGI applicants.
- Utilize electronic data sharing to verify eligibility and facilitate real-time enrollment for non-MAGI beneficiaries.

This brief outlines the importance of creating a single enrollment system for all Medicaid populations. It fleshes out the above recommendations and explains how the initiatives undertaken in New York can be replicated in other states.

Medicaid Expansion and Improvements Under the Affordable Care Act

In 2014, state Medicaid programs will have the opportunity to increase their eligibility thresholds for people under the age of 65 or ineligible for Medicare, providing Medicaid to those with incomes up to 138% of the FPL.⁵ States will be required to eliminate any asset or resource test, and use a modified adjusted gross income calculation to determine income, a departure from the existing net income test.⁶ Taken together, these measures will expand the number of people eligible for Medicaid, and will simplify and streamline the enrollment and renewal processes, ensuring that those who are newly Medicaid-eligible are enrolled and stay enrolled.⁷

The ACA further eases application and enrollment burdens for MAGI Medicaid beneficiaries: it prohibits the use of face-to-face interviews as a condition of eligibility, requiring states to accept electronic, phone, or facsimile signatures on applications. The ACA also requires states to utilize a single, streamlined application for MAGI Medicaid and qualified health plans (QHPs), the plans offered through states' health insurance exchanges.⁸ Such a single-point application model prevents disruptions in coverage as an individual's income and circumstances change, and eligibility shifts between Medicaid and the private plans in the exchange.

Important for this population, the ACA requires data sharing to populate and verify information on MAGI Medicaid applications.⁹ The intention of this provision is to provide states with a pathway to make real-time eligibility and enrollment determinations, and mitigate the need for applicants to provide paperwork that verifies information provided to the state on their applications. Regulations promulgated by the United States Department of Health and Human Services (HHS) envision a "Federal hub" that will share information among the states, the Social Security Administration (SSA), the Department of the Treasury, the Department of Homeland Security, HHS, and other agencies as determined needed and appropriate.¹⁰ Additional documentation from the applicant will only be required if: 1) the electronic data is not compatible with the

⁵ P.L. 111-148 § 2001, § 2002. Income limit includes a 5% automatic income disregard which effectively extends eligibility to 138% FPL.

⁶ *Id.*

⁷ Holahan, John and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State - by - State Results for Adults at or Below 133% FPL*, Kaiser Family Foundation (2010).

⁸ P.L. 111-148 § 1413

⁹ *Id.*

Medicaid Expansion and Improvements Under the Affordable Care Act *(continued)*

information provided by the applicant; or ²⁾ electronic data points are not available, and the cost of establishing a data match outweighs the harm of failing to establish the match.¹¹ To enable states to communicate with the Federal hub and make real-time eligibility and enrollment decisions, states have been provided with increased FMAP funding to modernize their eligibility and enrollment systems.¹² Once in place, such systems will more appropriately involve the state in sharing the documentation burden with beneficiaries to determine eligibility. In the past, placing the documentation burden solely on the beneficiary has resulted in applicants being denied benefits, not because they are ineligible but because necessary paperwork is missing or lost.

A SYSTEM IN NEED OF REPAIR

In October 2011, Mrs. D submitted her Medicare Savings Program (MSP) application to the local Department of Social Services (DSS). She included all of the paper documentation that was required, including proof of income and enrollment in Medicare. After three months, Mrs. D contacted the Medicare Rights Center, concerned that her application was lost. Because no electronic tool was available to check on the status of an application, Mrs. D and the Medicare Rights caseworker had to rely on e-mail and phone correspondence with the DSS office to determine the status of her application. In late February of 2012, Medicare Rights learned that Mrs. D was enrolled in the MSP in January 2012. However, the antiquated enrollment system had not generated an acceptance notice for Mrs. D, and more problematic, had not communicated the January acceptance and enrollment to the Medicaid payment system. Consequently, Mrs. D was still paying her Medicare Part B premium at \$99.90 per month—nearly 15% of her monthly income—which should have been paid by the MSP. Not until May 2012, another three months later, was this systems issue finally resolved. Mrs. D's MSP began paying her premiums—four months after she was determined eligible and seven months after she submitted her application.

Expanded eligibility categories and streamlined enrollment systems will mean that more uninsured New Yorkers will have access to health insurance coverage: an approximate 90,000 New Yorkers will be newly eligible for Medicaid.¹³ Beyond New York, these provisions could provide health insurance to more than 15.1 million adults in the United States, or nearly one-third of the people in this country who are currently uninsured.¹⁴ The expansion also offers savings

¹⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 C.F.R. 17143 (2012).

¹¹ Manatt Health Solutions, *Overview of Final Medicaid Regulation*, Robert Wood Johnson Foundation (2012).

¹² Center for Medicare and Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 2.0* (2011).

¹³ Boozang, Patricia, Melinda Dutton, et al., *Implementing Federal Healthcare Reform: A Roadmap for New York*, NYSHealth (2010).

¹⁴ Kennedy, Genevieve, Lisa Dubay, et al., *Opting Out of the Medicaid Expansion Under the ACA*, The Urban Institute (2012).

Medicaid Expansion and Improvements Under the Affordable Care Act *(continued)*

to state budgets, potentially reducing net spending on state and local government safety net programs for the uninsured by \$101 billion between 2014 and 2019.¹⁵

In addition to ensuring that more New Yorkers and more Americans have health insurance, eased recertification requirements and improved data sharing will mean that more eligible beneficiaries remain insured. This is particularly good news for a state like New York, where more than 30% of beneficiaries—many of whom are still eligible for Medicaid—unsuccessfully recertify for benefits each year and thus lose coverage.¹⁶

¹⁵ Angeles, *How Health Reform's Medicaid Expansion will Affect State Budgets*, *supra* note 2.

¹⁶ Perry, Michael, *Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus*, NYSEHealth (2009).

Left Behind: Non-MAGI Medicaid Beneficiaries

Unfortunately, for a large segment of Medicaid beneficiaries, Federal reform potentially leaves intact substantially more complicated and stringent eligibility rules, along with a complex and antiquated enrollment system to navigate. More specifically, older and disabled non-MAGI Medicaid beneficiaries may be relegated to a system that places the burden of application documentation squarely on their shoulders. Thus, if states do not seek a single system, then some of the most vulnerable populations—burdened by poverty, illness, and age—will be left to contend with a less generous set of eligibility rules, a more onerous application process, and an antiquated enrollment system.

Antiquated systems not only affect initial enrollment, as was the case for Mrs. D, they can also inhibit program recertification and retention of coverage. Currently, the recertification process in New York begins when a beneficiary receives a mailing from his or her local Department of Social Services (DSS) office containing a notification letter explaining the recertification process. Rather than DSS utilizing income data available to the State, as other states do,¹⁷ the recertification form asks that the beneficiary supply changes in information, such as income adjustments or changes in marital status, to the State and provide the documentation that supports these changes.¹⁸ Even if the beneficiary has no changes to report, it may be time consuming to process the recertification.

The process is not only costly for beneficiaries, it is also costly for states. The New York State Department of Health (NYSDOH) currently utilizes two eligibility and enrollment systems: the welfare management system (WMS) and eMedNY. WMS tracks program eligibility and enrollment, while eMedNY makes payments to providers and government agencies. These systems, however, are not tethered to one another. Instead, in most instances when a beneficiary loses Medicaid eligibility, a State worker must manually take action to record the disenrollment in both WMS and eMedNY.¹⁹ This lack of tethering can result in a disruption of coverage for beneficiaries and unnecessary costs for New York State. For example, if an

¹⁷ Louisiana, for example, passively recertifies individuals for Medicare Savings Programs.

¹⁸ A Medicaid Redesign Team proposal adopted in the 2011-2012 budget requires NYSDOH to begin implementing a passive recertification process for beneficiaries eligible for Medicaid due to age, blindness, or disability, or for an MSP; as of July 2012 the process is being tested in upstate counties.

¹⁹ Arnold, Judith, *Auto-Close Process for Medicare Buy-In*, General Information System Office of Health Insurance Programs (2009).

Left Behind: Non-MAGI Medicaid Beneficiaries (*continued*)

individual is determined to be no longer eligible for Medicaid, he or she would be removed from WMS. However, if the Medicaid worker does not also proactively remove the beneficiary from eMedNY, the State would continue to make payments to providers and other payers as though the person were still eligible for Medicaid.

The national eligibility and enrollment standards and procedures required by the ACA were a direct response to the often onerous eligibility rules and application procedures.²⁰ Studies have demonstrated that the more complex the application, eligibility determination, and recertification processes, the more likely individuals will fail to enroll or lose coverage.²¹ Thus eligible individuals and families lose coverage or are denied coverage solely because of difficult application or recertification procedures.²²

As noted, the ACA does not extend new eligibility and enrollment simplifications to the non-MAGI populations. More specifically, the data sharing mandate clearly outlined for the MAGI applicants does not reference the application of data sharing mechanisms to non-MAGI applicants. As a result, beginning in 2014, New York was on track to have a bifurcated Medicaid system, in which non-MAGI Medicaid applicants and recipients would be left in outdated systems that cannot share data with the Federal hub or even with other state systems.

²⁰ Morrow, Beth and Julia Paradise, *Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act*, Kaiser Family Foundation (2010); Weiss, Alice and Laura Grossman, *Paving the Enrollment Superhighway: Bridging State Gaps Between 2014 and Today*, National Academy for State Health Policy (2011).

²¹ Summer, Laura, *Increasing Participation in Benefit Programs for Low-Income Seniors*, Commonwealth Fund (2009).

²² *Id.*

Moving Toward a Single System in New York State and Lessons for Other States

Limiting the documentation required for non-MAGI applicants, verifying application data with other state and Federal agencies, and creating a uniform Medicaid application is possible under the ACA. Analyzing the law, regulations, and secondary sources, Medicare Rights determined that although the MAGI income calculation cannot by law be extended to the non-MAGI populations, many of the benefits gained by MAGI populations could be shared with non-MAGI applicants.²³ Medicare Rights engaged state and Federal policymakers to ensure that these benefits were provided to all Medicaid beneficiaries.

Of paramount importance to this effort—and Medicare Rights’ foremost recommendation to New York State and to the Federal government during this project—was the creation of a single enrollment system that could process applications for all populations in real-time, or as close to real-time as possible. This single system would achieve the “no wrong door” goal of the ACA. Ultimately, New York adopted the policy goal of creating a single enrollment system for all Medicaid beneficiaries, and Federal guidance moves all states toward a single system.

The following sections outline this and other steps that states can take to make new systems for the non-Medicare population more responsive to people with Medicare and other non-MAGIs.

RECOMMENDATION 1: Create a single, modernized enrollment system capable of processing applications for all Medicaid beneficiaries, including non-MAGIs.	
KEY STEPS:	
•	Design a single, modernized enrollment system.
•	Where necessary, stage incorporation of non-MAGIs into the new system, even if the entire population cannot be included in this system by 2014.
•	Base staged incorporation of non-MAGIs on the current application forms; applications that most closely parallel the MAGI Medicaid application can be integrated sooner.
•	Aim to complete a staged incorporation of all populations by 2015, when enhanced FMAP is no longer available.

²³Stein, Ilene, and Joe Baker, *A Bridge to Health*, Medicare Rights Center, Forthcoming 2012.

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

Because a bifurcated Medicaid system would by and large relegate non-MAGI beneficiaries to antiquated systems and cost states money to maintain two separate enrollment systems, it is important that states create a single enrollment system for all Medicaid beneficiaries. Such systems are financially supported by the United States Department of Health and Human Services (HHS), which increased the Federal Medical Assistance Percentage match to a 90%/10% Federal-state split through 2015, for states to work on creating modernized systems that facilitate Medicaid enrollment. Although not explicitly declared in the regulations, this enhanced match is available to modernize systems for both MAGIs and non-MAGIs. This financial boon to states, coupled with Federal guidance that requires electronic verification of available data for all Medicaid applicants, paves a path for states to more closely align the application, renewal, and enrollment systems for all populations, including non-MAGI beneficiaries.

The FMAP increase serves as a carrot for states to build a single eligibility and enrollment system, and Federal regulations provide the stick to guard against bifurcation. Final rules regarding Medicaid eligibility and enrollment note that HHS does not expect that states will continue to maintain two eligibility and enrollment systems.²⁴ Moreover, the rule is clear that Federal matching funds will not be available to support two enrollment systems; consequently, the financial burden of maintaining an antiquated system for non-MAGIs will fall on the state.²⁵ From an equity perspective as well as a cost perspective, it therefore behooves states to prevent bifurcation wherever possible.

A TALE OF TWO SYSTEMS: NAVIGATING A BIFURCATED MEDICAID PROGRAM

In 2014, shortly after Mr. R's 60th birthday, he suffers a stroke, becomes disabled, and qualifies for Social Security Disability Insurance. He suffers a loss of income, which places him at 137% of the FPL and qualifies him under the MAGI standard for Medicaid. Following a two-year waiting period for Medicare, Mr. R becomes Medicare-eligible when he is 62 years old. He is now a non-MAGI—and is no longer eligible for Medicaid because the upper income level for a childless non-MAGI is 85% of the FPL. Mr. R, now struggling to pay for needed health care, may be eligible for the MSP known as Qualified Individual (QI), but needs budgeting and income disregard advice. In a state that operates two separate Medicaid eligibility and enrollment systems, there is no trigger in place to notify Mr. R of this potential eligibility, provide him with counseling, or automatically enroll him in the QI program. Instead, he must contact the appropriate state agency and resubmit paperwork to qualify as a first-time applicant to QI, even though he recently had been eligible for full Medicaid. Moreover, unlike the MAGI Medicaid application process, which relies on data sharing and electronic verification, Mr. R may have to submit paper documentation to verify his income and assets, and wait a month or more before receiving an eligibility decision. And while he waits for a decision, Mr. R will continue to struggle to pay for needed care.

²⁴ 77 C.F.R. 17143.

²⁵ *Id.*

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

Although states may immediately recognize the financial incentive to build a single system, it may not be feasible to incorporate all non-MAGI populations into the new system by 2014. Yet even if states do not include all Medicaid populations in the new systems initially, they can design the systems so that incorporation of these populations after 2014 is possible. As noted above, states that do not will be left with the choice of financially supporting an outdated eligibility system for a subset of non-MAGI beneficiaries, or of creating potentially costly system workarounds to incorporate all Medicaid beneficiaries.

Staged integration of non-MAGI populations is possible. In New York, for example, the State Legislature approved several relevant recommendations made by the Governor’s Medicaid Redesign Team (MRT). These recommendations, which were informed by Medicare Rights and others, required the State to build a single eligibility and enrollment system for all Medicaid beneficiaries—including non-MAGIs—and acknowledged that all Medicaid populations can and should be brought into the system over time, if not by 2014.²⁶ New York decided that some non-MAGI populations should be incorporated by 2014, such as individuals applying for an MSP. These individuals could be relatively easily included in the new enrollment system because in New York—and other states with no MSP asset test—MSPs do not have an asset threshold, and documentation requirements are limited to proof of citizenship, residency, and Medicare eligibility. Drawing from this experience, states could look to their Medicaid programs that most closely parallel the MAGI Medicaid categories and mark them for an upfront integration. States could also follow New York’s lead and make efforts to incorporate all non-MAGI populations in advance of 2015 when the enhanced FMAP is no longer available.²⁷

RECOMMENDATION 2: **Align and simplify the application and renewal processes for MAGI and non-MAGI Medicaid applicants.**

KEY STEPS:

- Where possible, use the MAGI Medicaid application form for non-MAGI applicants.
- Accept electronic submission of non-MAGI applications and supplemental forms.
- Minimize application burdens and electronically verify data wherever possible.
- Redetermine non-MAGI eligibility in the same way as for MAGIs.
- Where a staged incorporation of non-MAGIs is necessary, employ passive recertification and other stopgap measures to simplify application and renewal processes.

²⁶ New York State Department of Health, *Medicaid Redesign Team, Program Streamlining and State/Local Responsibilities Work Group, Final Recommendations* (2011).

²⁷ *Id.*

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

On March 23, 2012, HHS published its final rule, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” (Medicaid Eligibility Rule).²⁸ This final rule, influenced in part by the comments of Medicare Rights and other advocates, takes steps to encourage states to align their Medicaid application and renewal processes for MAGI and non-MAGI applicants. States can take advantage of this opportunity to streamline their enrollment and renewal processes, and ensure that eligible beneficiaries are not denied or knocked out of benefits owing to burdensome application or documentation requirements.

IMPORTANT PROTECTIONS FOR NON-MAGI BENEFICIARIES OUTLINED IN THE FINAL FEDERAL RULE

NON-MAGI MEDICAID APPLICATIONS

A separate application for non-MAGIs must meet the same HHS guidelines as the MAGI application.

Non-MAGI applications should be accepted through all pathways, including electronic submission.

RECERTIFICATION PROCESS FOR NON-MAGI BENEFICIARIES

Medicaid Department of Social Services (DSS) offices must first look to data already available to the state before asking Medicaid beneficiaries, including non-MAGIs, to provide additional information.

DATA SHARING AND VERIFICATION PROCESSES FOR NON-MAGI MEDICAID APPLICATIONS

States are encouraged to utilize the self-attestation verified by electronic sources for all applicants.

States may require paper documentation only when electronic documentation is not compatible with the information provided by the applicant, or electronic data is not available and the cost of establishing an electronic data match outweighs the impact on eligible individuals being denied coverage.

In support of alignment and simplification states are now permitted to use the MAGI Medicaid application for non-MAGI applicants, and attach supplemental forms to collect additional needed information, or to create a new non-MAGI application. Federal guidance further mandates that separately developed applications and supplemental forms must minimize the burden on applicants and meet all secretarial guidelines for MAGI Medicaid applications. For instance, as states begin to utilize electronic data exchange for all Medicaid populations, supplemental forms should be updated to ensure that beneficiaries are not being asked to supply documentation for categories that will be or have already been electronically verified.

²⁸ 77 C.F.R. 17143.

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

In addition to streamlining the Medicaid application itself, states can ensure that the non-MAGI applications and supplemental forms are accepted electronically, as Federal guidance encourages and as is already mandated for MAGI populations.²⁹ To this end, as non-MAGI populations are built into a single eligibility and enrollment system, it is critical that their applications are designed in a way that will allow for electronic submission and acceptance. Such a process will facilitate information exchange and real-time eligibility decisions.

In addition to taking steps to improve the application process for both MAGIs and non-MAGIs, the Federal guidance is clear that state Medicaid agencies must redetermine eligibility for non-MAGI beneficiaries using the same administrative renewal process described for MAGI populations.³⁰ Thus Medicaid agencies must first look to the data already available to the state before asking Medicaid beneficiaries to provide additional information. This requirement underscores the importance of ensuring that data exchange improvements in the MAGI eligibility system are extended to non-MAGI beneficiaries (as discussed in greater detail under the next recommendation). The more data that is available to the Medicaid office, the less information the beneficiary will need to supply or verify. In fact, the majority of beneficiaries could be passively recertified, and states could conduct proactive outreach to beneficiaries whose information is incomplete or inconsistent. Not only would this save beneficiaries time, it would also enable states to focus their resources on cases where the system has identified an issue, rather than on each renewal.

States that are not able to immediately integrate all non-MAGI populations into the new enrollment system, and that consequently cannot uniformly simplify their application and renewal processes, can still take steps to simplify these processes. For instance, states can enact laws or implement regulations that require passive recertification for all Medicaid beneficiaries, including non-MAGIs. Louisiana and New York have already implemented passive recertification for certain non-MAGI populations. New York, for example, is in the process of rolling out passive recertification for MSP beneficiaries and full Medicaid beneficiaries who are receiving only Social Security Income (SSI).³¹ The State will rely on data from the Social Security Administration and send out a pre-populated letter with the beneficiary's most recent information. Beneficiaries will only be asked to respond if the data is incorrect or if there is a

²⁹ *Id.*

³⁰ *Id.*

³¹ Passive recertification for this population was advocated for by Medicare Rights and is more fully explored in a brief prepared with NYSHHealth: Goggin-Callahan, Doug, *Recertification in New York State: The Revolving Door of the Medicare Savings Program*, Medicare Rights Center (2011).

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

change to report; otherwise, the benefit is renewed for another year. Although this process is not perfect, it capitalizes on data sharing and eases the burden on beneficiaries, both of which are goals of the ACA.

RECOMMENDATION 3: **Utilize electronic data sharing to verify eligibility and facilitate real-time enrollment for non-MAGI beneficiaries.**

KEY STEPS:

- Verify non-MAGI Medicaid application information through the Federal hub.
- In cases where non-MAGIs are not yet participating in the Federal hub, employ stopgap measures to electronically verify application data, and enroll individuals in additional benefits where applicable.
- Invest in asset verification systems where possible.

As discussed throughout this report, the ACA envisions seamless coordination among Federal and state entities, and uses data sharing as a tool to streamline applications, eligibility determinations, enrollment, and benefit recertification. Consequently, for non-MAGI beneficiaries to share in the eligibility and enrollment improvements available to MAGI beneficiaries, it is important that states utilize data sharing for all Medicaid populations.

Ideally, non-MAGI beneficiaries would have their information verified through the Federal hub. As noted, however, states may stage the incorporation of non-MAGI populations into the single system, and those outside the new system may not be able to participate in the hub. Yet, even for populations outside the hub, data sharing opportunities are available to states. For example, in an effort to increase enrollments, information obtained by the Supplemental Nutrition Assistance Program (SNAP) can be used to trigger an application for the Children's Health Insurance Program (CHIP).³² Similarly, New York is working within its existing system to identify opportunities to utilize shared data. The State is, for instance, exploring ways in which it could utilize billing data from eMedNY—its payment and billing system—to verify ongoing eligibility for the Medicaid excess income program (i.e., the program in which income over the Medicaid level is spent down with paid or unpaid, but current, medical bills).

States could also explore investing in tools to assist in data verification from third-party sources. For instance, as the result of an MRT proposal championed by Medicare Rights,

³² Summer, Laura, *Express Lane Eligibility: New Strategies for Increasing Enrollment*, National Council on Aging (2009).

Moving Toward a Single System in New York State and Lessons for Other States *(continued)*

New York has committed to investing in an Asset Verification System (AVS). AVS providers work with a number of financial institutions to verify asset data provided by applicants. The system can request information on both open and closed accounts, going back five years. AVS providers are required to make these requests electronically and receive responses electronically. States like Mississippi have mandated that, at a minimum, the AVS be capable of verifying checking, savings, and investment accounts; IRAs; treasury notes; certificates of deposit; annuities; and any other assets that may be held or managed by a financial institution.³³ Using AVS, states could verify asset information for non-MAGI beneficiaries.

Moreover, given that most AVS systems are capable of verifying assets from five years prior, these systems could begin to automate the Medicaid application process for non-MAGI beneficiaries applying for Medicaid benefits, such as long-term care, that require the reporting of past assets as well as current assets. Typically, these populations have more complicated eligibility rules and would be the most difficult to integrate into a new enrollment system. The AVS could be a first step to streamlining the eligibility and enrollment processes for these more complicated eligibility categories.

An AVS would cost states money, but could represent an excellent investment. In New York, for example, the AVS was budgeted at \$2 million. Cost aside, the AVS will move states in the direction of a single enrollment system that utilizes electronic data sharing and could facilitate a more rapid incorporation of all Medicaid populations into the new enrollment system. This could allow states to capitalize on the enhanced Federal match funds and guard against having to financially maintain an outdated system.

³³ Mississippi Division of Medicaid, Requests for Proposals for an Asset Verification System Provider, 2011.

The Road Ahead

The ACA, augmented by recent Federal regulations, establishes a clear choice for states: utilize increased Federal match funds to build a new enrollment system for all Medicaid beneficiaries, or administer a bifurcated program and financially support the maintenance of an antiquated system. Both budget and equity arguments support the creation of a single system for MAGI and non-MAGI beneficiaries.

Moreover, states should not be discouraged from establishing a single enrollment system simply because not all non-MAGI populations can be moved to this system before 2014. Phased implementation is possible. As states build new eligibility and enrollment systems for the MAGI population, they can quickly phase in less complex non-MAGI populations. As noted, MSP applications require very little documentation. These benefits represent low-hanging fruit for incorporation and should be moved into the new system quickly so that states can focus on incorporating the more complex non-MAGI populations.

As states phase Medicaid populations into new enrollment systems, state health departments should explore opportunities within existing systems to automate and share data. Passive recertification and asset verifications are two avenues to explore, and there may be other opportunities unique to a particular state's system, such as the eMedNY billing data in New York. States may also want to consider creating their own state "data hub," which can share information among state agencies—particularly state tax departments.

State departments of health are under pressure to build state health insurance exchanges, expand the Medicaid program, and build a new Medicaid enrollment system by 2014. With such pressing deadlines, states may be tempted to delay the phase-in of non-MAGI beneficiaries or table the issue altogether. If, however, a state waits until 2014 to consider the inclusion of non-MAGIs, the state could inadvertently create a bifurcated Medicaid program—a program that is burdensome to both its citizens and its budget.



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VOICE: 212-664-7656

FAX: 646-421-6029

MAIL: 1385 Broadway,
23rd Floor

New York, NY 10018

WEB: www.nyshealth.org