

State Innovations in Horizontal Integration:

Leveraging Technology for
Health and Human Services

March 24, 2015



Acknowledgements

The authors wish to express gratitude to the state officials who generously shared their time and contributed information and insights about their horizontal integration efforts: Alabama Department of Human Resources; California Department of Health Care Services, California Department of Social Services; Colorado Department of Health Care Policy and Financing; Idaho Department of Health and Welfare; Illinois Department of Human Services; Kentucky Office of Administrative & Technology Services; New Mexico Human Services Department; Office of Entitlement and Insurance, State of Oklahoma; Pennsylvania Bureau of Information Systems; Vermont Agency of Human Services; Office of the Secretary of Health and Human Resources, Commonwealth of Virginia.

The Center on Budget and Policy Priorities thanks the Center for Law and Social Policy and the Work Support Strategies Project for their support.

Social Interest Solutions (SIS) would like to thank the California HealthCare Foundation (CHCF) based in Oakland, California for co-funding this report and Catherine Teare from CHCF for providing insightful comments. SIS also thanks the following individuals who provided critical feedback and guidance: officials from the Centers for Medicare and Medicaid Services, Food and Nutrition Services, and Administration for Children and Families; Anita Light and Meghan Lape, American Public Human Services Association; Alice Weiss, National Academy for State Health Policy; Stan Dorn, Urban Institute; and Kim McCoy Wade.

Updated March 24, 2015

State Innovations in Horizontal Integration: Leveraging Technology for Health and Human Services

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Executive Summary

Because most low-income individuals and families qualify for multiple public benefit programs, most states have a long history of using the same technology and staff to process eligibility for the means-tested programs that they administer, such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). Such integrated eligibility systems and processes are cost-effective for states because they avoid duplication of effort. They also promote low-income individuals' access to the full package of benefits for which they qualify, helping them meet their needs for nutritious food, medical care, affordable child care, and other basic living expenses.

The Affordable Care Act (ACA) required states to make large-scale changes to their eligibility systems for Medicaid in order to create streamlined processing with the health plan coverage and subsidies that are available through health insurance marketplaces (also known as exchanges). To support these changes, the U.S. Department of Health and Human Services (HHS) made enhanced federal Medicaid matching funds available for states to update or build their systems. In recognition of the efficiencies of integrating these systems with non-health programs, states have also been given the opportunity of a cost allocation waiver that allows them to temporarily use this enhanced funding to support technology and services improvements to eligibility systems shared by Medicaid and other health and human services programs.

This issue brief highlights examples of technology and services innovations that states are implementing in support of integration among health and human services programs and discusses common themes across efforts. These examples, which are not exhaustive, are culled from interviews with federal experts and state officials from Alabama, California, Colorado, Idaho, Illinois, Kentucky, New Mexico, Oklahoma, Pennsylvania, Vermont, and Virginia.

States have taken a wide range of approaches in leveraging their ACA implementation efforts to support a broader range of human services programs. Though the degree of integration varies widely across states, most states featured in this brief have implemented or are planning innovations in one or more of the following areas:

- **Client portals:** States are making information and services available to consumers through client web portals.
 - Eligibility screening tools can promote cross-program enrollment by helping consumers learn they may qualify for programs that they may not otherwise have been aware of;
 - Multi-benefit online applications guide applicants through dynamic questions to receive eligibility determinations for multiple programs; and
 - Self-service case management features enable consumers to obtain information about and manage their benefits (such as updating case information) through a single point of contact.
- **Eligibility systems and business rules engines (BREs):** States are enhancing integrated eligibility systems by programming rules for multiple health and human services programs into BREs. These efforts can automate calculations and tasks to achieve significant efficiencies for states throughout the eligibility and enrollment process. They can also dramatically shorten the eligibility determination process for consumers across a range of programs, in some cases allowing for real-time determinations.
- **Call center technology:** Advanced call center technologies are allowing states to appropriately route calls to the staff with the skills and expertise needed to address callers' needs. These technologies give states the flexibility to make optimal use of both generalists who can address questions about all programs and specialists in particular programs or types of issues. They also give states the flexibility to route calls wherever workers are located, allowing for "virtual" call centers with more efficient allocation of staff resources.
- **Electronic data matching:** Using electronic data matching to verify eligibility factors can save consumers who apply for multiple programs from having to provide the same paper documents multiple times. Some states are implementing new state hubs that consolidate data from multiple sources, making it easier for workers to access and process the information across programs as needed.
- **Document imaging and management:** States are using document imaging and management systems to support streamlined processing of paper documents across multiple programs. These systems make it easier for multiple workers to be involved in a single case as needed over time and across programs, facilitating handoffs among different programs or units of workers, such as call center representatives and workers in local eligibility offices.
- **Data management and analytics:** States are examining ways to make better use of health and human services data to improve program operations and outcomes for clients. Data management and analytic tools allow states to merge data from multiple sources (e.g., case records and claims databases) and analyze it at the case, program, or population level to support better decision-making.
- **Mobile tools:** States are in the early stages of exploring how mobile tools can help consumers understand, access, use, and maintain their benefits. Some states are starting with optimizing their client portals for tablets. A small number have developed or are exploring mobile "apps." Other states are looking for ways to incorporate mobile tools into their workflow.

Although the states included in this study are taking a variety of technology approaches toward horizontal integration, some common themes have emerged. States have emphasized the

importance of executive-level leadership and collaboration across health and human services agencies to provide governance. They also have stressed the critical role of business process reengineering as a driver for technology projects. Though states are using a blend of funding streams, they are carefully considering how best to capitalize on the enhanced federal funding opportunity and cost allocation waiver, particularly in light of a recent extension of the waiver for building or upgrading systems through 2018. They also expect that data and analytics emerging from their technology efforts will help them adjust their horizontal integration approaches for better results and plan for future policy, operational, and technology changes. The features profiled in this brief can serve as examples to help states improve their operating efficiencies while allowing them to better meet their constituents' needs.

Introduction

The Affordable Care Act (ACA) required states to make large-scale changes to their eligibility systems for Medicaid in order to create streamlined processing between Medicaid and new health plan coverage and subsidies that are available through health insurance marketplaces (also known as exchanges). To support implementation of these changes, the U.S. Department of Health and Human Services (HHS) made enhanced federal Medicaid matching funds available for states to update or build such systems (as well as to support their ongoing maintenance). Specifically, CMS temporarily increased the federal Medicaid matching rate from the regular 50 percent rate for administrative expenditures to a 90 percent rate for expenditures related to the design, development, and implementation of new or upgraded systems. It also permanently increased the 50 percent rate to 75 percent for expenditures related to the maintenance and operations of any new or upgraded systems, provided the systems meet (and continue to meet) specified standards and conditions.

In recognition of the efficiencies that states (and the federal government) would accrue through integrating these new or upgraded systems with non-health programs such as Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), the federal government also allowed states to temporarily waive “cost allocation” rules that require states to charge each program for its share of technology costs, so that the enhanced funding can support multiple programs. While the new funding created an unprecedented opportunity for states to update or replace outdated systems, the tight timeframes and high expectations and demands for ACA implementation created substantial challenges for states to take full advantage. In late 2014, the Obama Administration announced its intention to make the enhanced funding for Medicaid systems permanent and to temporarily extend the enhanced funding opportunities for integrated eligibility systems through December 2018.

This paper highlights examples of technology innovations that states are implementing in support of integration among health and human services programs and discusses common themes across efforts. The examples illustrate a range of options for states to consider as they seek to promote effective, streamlined, and integrated means of supporting individuals and families while drawing down time-limited enhanced federal funding.

Background

Horizontal Integration

Health and human services programs help people with low incomes meet their needs for nutritious food, medical care, affordable child care, and other basic living expenses. Evidence suggests that people who participate in programs such as Medicaid and SNAP not only experience fewer short-term hardships but also achieve positive longer-term outcomes in employment, earnings, and overall well-being.¹ The Center on Budget and Policy Priorities has provided technical support to six states through the Work Supports Strategies project, seeking to improve how they deliver key work supports horizontally. (See Box 1.)

Although the state-administered health and human services programs have different eligibility rules based on differences in federal law across programs and the flexibility states have to implement the programs within federal parameters, much of the information that states need to establish eligibility, such as details about family members and their incomes, is common across the programs. Furthermore, a large share of the families with members who qualify for one program also qualify for other programs. SNAP, for example, is generally available to households with gross income below 130 percent of the federal poverty level, while Medicaid now covers individuals in families up to 138 percent of the federal poverty level in states that expand Medicaid under the ACA. Even states that have not expanded Medicaid provide health coverage to children at or above 138 percent of the federal poverty line (and they also generally cover parents at some level below the poverty line, as well as other individuals such as seniors, people with disabilities, and pregnant women who meet certain categorical eligibility requirements). Nearly all SNAP-eligible families with children also have at least one member who is financially eligible for Medicaid.

Box 1: Work Support Strategies

This report was written in coordination with the Work Support Strategies Project. Work Support Strategies (WSS) is a multiyear, multi-state initiative to help low-income families get and keep the package of work supports for which they are eligible. WSS has been working directly with Colorado, Idaho, Illinois, North Carolina, Rhode Island, and South Carolina since 2011. Through grants and expert technical assistance, WSS helps states reform and align the systems delivering work support programs intended to increase families' well-being and stability — particularly SNAP, Medicaid and the Children's Health Insurance Program (CHIP), and child care assistance through the Child Care and Development Block Grant. Through WSS states seek to streamline and integrate service delivery, use 21st Century technology, and apply innovative business processes to improve administrative efficiency and reduce burden on states and working families.

The Center on Budget and Policy Priorities coordinates the Technical Assistance for the project. Our work in this effort helped to inform this paper.

For more information about WSS, see: <http://www.clasp.org/issues/work-support-strategies>

As a result, it is highly efficient for states to “horizontally” integrate their eligibility systems and processes across health and human services so they do not need multiple systems and staff to process eligibility for the same individuals. (See Box 2.) Moreover, integrated eligibility processes are less burdensome for families because they can provide the same information to multiple programs at the same time.

Prior to implementation of the ACA, about 45 states administered health and human services jointly for the lowest-income families. That is, when a family applied for a human services program it could have its eligibility determined for health coverage through the same process, and in almost every case the eligibility systems that determined eligibility and issued benefits also were integrated.²

Nevertheless, many people did not participate in all of the programs for which they were eligible, for several reasons. First, when applicants applied through the human services system in most states, they often were considered only for the programs they request to apply for, rather than all programs for which they may be eligible. Second, in addition to their integrated processes for human services

programs, many states also had separate child health insurance programs and procedures that were not integrated, even though some of the families with eligible children might qualify for other human services programs. And third, families sometimes were out of compliance with procedural requirements for one, but not every, program. This can be especially true when eligibility periods are not aligned, requiring the family to respond to multiple notices over the course of several months.

In 2011, an estimated 27 million children (35 percent of all children in the United States) were eligible for both health coverage benefits (Medicaid or the Children’s Health Insurance Program, CHIP) and SNAP.³ However, a significant portion of those children were not enrolled in one or more of the programs for which they were eligible. A study of participation rates in five states found that only between 61 percent and 81 percent of children jointly eligible for Medicaid/CHIP and SNAP in 2011 were enrolled in both health coverage and nutrition benefits.⁴

To illustrate the value of integration, consider a scenario in which a low-income working family is interested in receiving Medicaid, SNAP, and child care subsidies. In a state with relatively siloed programs, the family may have to fill out three highly redundant forms collecting essentially the same information about their family circumstances and income; provide the same or similar verification documents multiple times; and otherwise communicate with three separate points of contact to follow up and manage benefits over time. Similarly, eligibility workers in each program may perform similar tasks in terms of entering data, calculating income, verifying application data against third-party data sources, following up with the family, and otherwise processing eligibility and enrollment.

Meanwhile, in a state with more tightly integrated systems, the family might be able to fill out a single multi-benefit application (paper, online, or by phone), provide any necessary follow-up information to a single point of contact, and have that information used to determine eligibility for multiple programs. The information may flow to an automated system that can perform some tasks, such as routine income calculations according to each program’s rules; call up other systems to obtain and assess verification data; and route the information and results to other systems or to workers as needed for further processing.

Box 2: What Is Horizontal Integration?

In general business terms, “horizontal integration” refers to the merger of firms that operate at the same stage of production to achieve economies of scale. The merger of competing light bulb manufacturers to increase their collective market share and lower the unit cost of production is an example of horizontal integration.

In the realm of health and human services, “horizontal integration” usually refers to the sharing of data, policies, processes, technology, and/or staff across programs to streamline eligibility and enrollment. This paper focuses on states’ adoption of shared technology and services innovations across means-tested programs that support individuals’ and families’ health and human services needs, such as Medicaid, SNAP and TANF. These shared technology solutions promote individuals’ and families’ access to the programs and administrative efficiencies for states. Since the ACA made affordable health coverage available to people through different programs based on their income, much of the integration efforts under the ACA have focused on “vertical integration” of health coverage programs (Medicaid, CHIP, and marketplace coverage). However, ACA implementation provides substantial opportunities for horizontal integration as well.

Impact of the ACA on Eligibility System Development

The ACA established new expectations for eligibility and enrollment processing of health coverage programs, including Medicaid. For example, states must make it possible for people to apply for health coverage in person, by mail, by phone, and online; rely on electronic sources to verify eligibility information; and coordinate eligibility among all health coverage programs.⁵ Optimizing technology improvements can streamline these functions and benefit states, workers, and consumers (see Box 2).

To support ACA implementation, the Centers for Medicare and Medicaid Services (CMS) made available enhanced federal funding for modernizing Medicaid eligibility and enrollment systems according to ACA requirements. Specifically, CMS temporarily increased the federal Medicaid matching rate from the regular 50 percent rate for administrative expenditures to a 90 percent rate for expenditures related to the design, development, and implementation of new or upgraded systems. It also permanently increased the 50 percent rate to 75 percent for expenditures related to the maintenance and operations of any new or upgraded systems, including eligibility staff time spent on the systems.⁶ The systems must meet (and continue to meet) specified standards and conditions. (These standards and conditions are described in Appendix C.) The 90 percent matching rate was originally intended to be available only through December 2015, but CMS recently announced its intent to make it permanent.⁷

While increasing expectations for Medicaid eligibility and enrollment, the ACA has also indirectly affected horizontal integration. On the one hand, in states expanding Medicaid under the ACA, the expansion increases the likelihood that low-income individuals and families will be simultaneously eligible for multiple health and human services programs. If Medicaid were expanded in every state, an estimated 99 percent of TANF recipients, 97 percent of SNAP recipients, 92 percent of housing subsidy recipients, and 90 percent of child care subsidy recipients would also be eligible for Medicaid.⁸ This increase in joint eligibility provides further rationale for horizontal integration efforts.

On the other hand, the practical realities of meeting the tight timeframes and high expectations and demands of ACA implementation have posed some risks to horizontal integration efforts that most states had implemented prior to the ACA. Many states had eligibility systems dating back to the 1980s (that may have been modified over the years) to determine eligibility and issue benefits for multiple programs, such as Medicaid, SNAP, and TANF. To meet timeframes for transitioning Medicaid to ACA-compliant systems, many states chose to leave the other programs on the old systems, at least temporarily. This de-coupling of Medicaid from human services programs has the potential to undermine states' ability to deliver benefits jointly to low-income individuals and families.⁹

To mitigate those risks and promote efficiency and better customer service, federal agencies that oversee Medicaid, SNAP, TANF, child welfare, and other health and human services programs have taken steps to encourage states to leverage their modernized Medicaid systems to benefit other programs.

Cost Allocation Waiver

Generally, federal rules allow states that administer federally funded programs to share resources, such as staffing and technology, across programs so long as the associated costs are allocated across the programs and charged back to the federal government according to each program's federal funding rules. These cost allocation guidelines are set by the Office of Management and Budget (OMB) in OMB Circular A-87.¹⁰

In recognition of the potential for Medicaid system modernization to benefit other health and human services programs that require much of the same eligibility and enrollment information and processes, OMB and federal agencies originally offered a time-limited waiver of the cost allocation rules through 2015.¹¹ The waiver allows human services programs (such as SNAP, TANF, and child care programs) to use systems the state designed or upgraded for determining eligibility for Medicaid under the ACA without sharing in the financing of the common costs of system developing. However, those system costs related solely to the administration of the other programs and not of benefit to Medicaid must still be allocated to the other programs and paid at the usual federal matching rates for those programs. In addition, the waiver does not apply to operating and maintenance expenses, which must also still be allocated to the other programs and paid at their usual federal matching rates (typically 50 percent).¹²

Box 3: How Technology Can Impact Horizontal Integration

Technology presents opportunities and risks for horizontal integration efforts. Many states have been working for years to use technology better to streamline program eligibility and enrollment. Sharing technology solutions across health and human services programs can also promote consumer access. For example:

- Online applications and portals can provide consumers the ability to understand and manage their benefits through a single point of contact, allowing them to apply for multiple programs at once.
- Robust eligibility systems and rules engines can reduce the need to engage in routine, redundant tasks, freeing staff up to focus on more complex matters that do not lend themselves to automation, such as providing application assistance, answering technical questions, and processing complicated cases.
- Systems can also reduce duplication of effort by bridging variations in rules and processes across programs and by easing system change and staff training requirements when policy changes occur.

For these benefits to be realized, the technology solutions must be well-designed and implemented in concert with effective off-line processes for individuals and families who do not have access to technology or otherwise can benefit from personal help. Without this, technology can also hinder consumer access. For example:

- States may use old, outdated, or imprecise electronic verification sources that may contradict accurate statements consumers make about their circumstances on their applications.
- States may expect technology to reduce their staffing needs, but if expected time savings don't materialize, the state is not easily or quickly able to readjust staffing levels —possibly resulting in backlogs, errors, and delays in consumers accessing needed benefits.
- States may close in-person access to eligibility workers, making it difficult for some consumers with limited or no Internet access.

Combined with the enhanced funding for Medicaid eligibility and enrollment system modernization, this waiver significantly lowers state costs for integrating eligibility determination functions across health and human services programs. The majority of states have requested and received approval from CMS to use this waiver.¹³ CMS recently indicated its intent to extend the A-87 cost allocation waiver for another three years, through December 2018, “to enable states to complete their work on eligibility and enrollment system integration.”¹⁴

State Innovations

Objective and Methodology

We set out to identify strategies states have taken to use the enhanced funding opportunity and cost allocation waiver to support their horizontal integration efforts, with the goal of providing state officials and other stakeholders with examples of innovations they can consider adopting. We specifically looked for examples of technologies that promote individuals and families’ ability to learn about, apply for, enroll in, and retain benefits across an array of public health and human services programs. These examples, which are not exhaustive, are culled from interviews with state officials and review of public documents. We sought to identify states that varied in terms of population size, region, marketplace model, adoption of the Medicaid expansion, and extent of horizontal program integration prior to ACA implementation. A list of the interviewed states and their key attributes is provided in Appendix B. Interviews were conducted in late 2014.

Overview of Findings

States have taken a wide range of approaches to leveraging their ACA implementation efforts to support a broader range of human services programs. Due to the time constraints and pressure to implement the ACA, states generally used the enhanced funding opportunity to first implement systems to support changes in Medicaid eligibility rules and processes. In some cases, integration of human services programs into the modernized ACA systems happened nearly in lock step, leveraging the cost allocation waiver. In other cases, states that had integrated health and human services programs prior to the ACA’s passage are now temporarily processing Medicaid eligibility in a separate eligibility system but intend to migrate additional health and human services programs to the new systems in future phases of implementation.

The extension of the A-87 cost allocation waiver through 2018 gives these states additional time to complete the migration, as well as providing states with less-tightly integrated programs additional time to make further Medicaid improvements and leverage them for other health and human services programs.

Though the degree of integration varies widely across states, most states featured in this brief have implemented or are planning innovations to more than one business process or technical system. This section outlines examples of innovative efforts to promote horizontal integration in the following functional areas: client portals (including multi-benefit online applications), eligibility systems and business rules engines, call center technology, electronic data matching, document imaging and management, data management and analytics, and mobile tools. Following the review of state

innovations is a discussion of common themes that emerged across states relating to governance, business process reengineering, cost allocation, and performance improvement.

Client Portals

Client portals are websites that organizations use to give their clients access to information and services. While general information about the organization and its services typically is available to anyone who visits the site, consumers typically have to log on to a personal account to access information that is specific to them or to conduct more complex or personal transactions. For example, a bank's client portal may provide general information about the services the bank offers and access to basic financial tools like mortgage calculators for all site visitors. To access bank account balances, transfer funds among bank accounts, and conduct other banking business through the client portal, the bank's clients would need to log in to their secure online account.

Health and human services agencies similarly use client portals to provide a spectrum of online consumer supports. Typically, their client portals provide general information about available programs and also allow consumers to create an account and log on to access more features, such as online benefits applications. Through these portals, consumers can learn about available programs, get answers to routine questions, quickly assess whether they are likely to qualify, and conduct some business with the programs on a self-service basis, all through a single point of contact at their convenience. As a result, well-designed portals can help reduce the time program staff spend providing routine information and services to individuals who have Internet access and choose to seek information online.

This section describes three specific functions that states are making available through their client portals to promote horizontal integration: eligibility screening tools, multi-benefit online applications, and self-service case management features.

Eligibility Screening Tools

Eligibility screening tools allow consumers to find out for which programs and services they may be eligible based on their answers to a more limited set of questions than is required in a full application for benefits. These screening tools are typically available to all visitors to the site, without having to create an account or enter personally identifiable information.

When used to screen for multiple programs, screening tools can promote cross-program enrollment by helping individuals and families identify and apply for programs that they may not otherwise have been aware of. While screeners are not perfect predictors of eligibility, they can help a large share of consumers find the most appropriate application process to meet their needs and may help reduce delays in processing of their benefits.

Some states make available multi-benefit screening tools that assess consumers' likely eligibility for an array of health and human services programs. These screening tools guide consumers to the next steps for completing the appropriate application process for each program for which they are likely eligible, based on their answers to the screening questions. For example, the MyAlabama portal allows people to take a six-page survey and receive information about a large number of Alabama's health and human services programs and how to apply for them, including links to online applications where available. Users can print the results for future reference. Pennsylvania's

screening tool assesses potential eligibility for a wide variety of health and human services programs, many but not all of which are included in the state's multi-benefit online application (see below). Depending on the results of the screening tool, consumers are directed to the multi-benefit online application and/or other options to apply for benefits.

Some states that are supported by healthcare.gov use eligibility screening tools to direct consumers to the best pathway for obtaining health coverage. Consumers who are likely to be eligible for marketplace coverage are directed to healthcare.gov, while those likely to be eligible for Medicaid or CHIP are directed to the relevant application process for those programs in their state. In states where consumers can apply for Medicaid, CHIP, and human services programs through a single application, this use of an eligibility screening tool can promote cross-program enrollment. For example, both Illinois and Virginia have client portals that are focused on health coverage and are heavily marketed during annual marketplace open enrollment periods. An eligibility screening tool on the Get Covered Illinois site directs consumers who are likely eligible for Medicaid or CHIP to Illinois' Application for Benefits Eligibility (ABE), a multi-benefit online application that consumers can also use to apply for TANF and SNAP (see Appendix A for more information about Illinois). Similarly, health coverage outreach efforts in Virginia lead consumers to the Cover Virginia site, where they can use an eligibility screening tool to assess their potential eligibility for Medicaid, CHIP, and marketplace coverage. Those who are likely eligible for marketplace coverage are directed to healthcare.gov, while those who are likely eligible for Medicaid or CHIP are directed to the CommonHelp client portal. Virginians can apply for health coverage, TANF, child care, energy assistance, and SNAP through CommonHelp.

Multi-benefit online applications

Many states allow people to apply for multiple public benefit programs using a single online application. Typically, these multi-benefit online applications include Medicaid, CHIP, SNAP, and TANF, at a minimum. Applicants can answer a single set of questions at a time, pace, and place of their convenience and receive eligibility determinations for multiple programs. States benefit from a single intake process with minimal involvement of workers; the information from the application can flow to any number of systems for further processing as needed.

Most states had multi-benefit online applications prior to the passage of the ACA.¹⁵ Some states have used the enhanced funding opportunity to modernize their applications, interface with marketplace systems and incorporate changes needed for ACA, such as income counting methods for Medicaid known as Modified Adjusted Gross Income (MAGI). (MAGI, however, does not apply to certain Medicaid beneficiaries such as seniors and people with disabilities on Supplemental Security Income.) For example, Pennsylvania updated the wording and sequencing of application questions and integrated the MAGI methods into its existing COMPASS application (in use since 2002), which supports Medicaid, SNAP, TANF and the Low-Income Home Energy Assistance Program (LIHEAP). COMPASS is also tightly integrated with the separate online CHIP application, operated out of the state's Department of Insurance. Data is passed between the separate eligibility systems supporting these programs. Colorado also has updated its multi-benefit online application (PEAK) to incorporate real time decisions for Medicaid based on MAGI, Child Health Plan *Plus*, and marketplace coverage and subsidies, in addition to continued support for non-MAGI medical, SNAP, TANF, and other programs.

Other states replaced multi-benefit online applications or implemented new ones.

- Illinois launched a new multi-benefit online application (ABE) for SNAP, TANF, and Medicaid, a replacement that was based on an online application used in Michigan.
- Kentucky is implementing two online applications that refer consumers between them and will be supported by a single underlying eligibility system. A multi-benefit health application available through the client portal for Kentucky's state-based marketplace (SBM), called kynect, provides access to Qualified Health Plans and subsidies as well as Medicaid based on MAGI. A second online application that Kentucky will launch on a separate portal under development will provide access to Medicaid, TANF, SNAP, child care assistance, and LIHEAP. In addition, this portal will collect application data and conduct a pre-determination of eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and forward the data to the WIC office for final determination (see Appendix A for more information about Kentucky).
- New Mexico implemented its Yes New Mexico online application for Medicaid, TANF, SNAP, LIHEAP, and General Assistance in October 2013. When the state launches its SBM next year, the insurance affordability programs will be integrated into this application with real-time eligibility for Medicaid and SBM coverage and subsidies.

States have structured their multi-benefit online applications in a variety of ways. Some states, like New Mexico, require applicants to choose their programs of interest at the beginning of the application process; the application is then automatically tailored to ask only the questions that are relevant to the programs the applicant selected. Colorado's PEAK application takes a similar approach, giving applicants the option of choosing among medical assistance, food assistance, two different types of cash assistance, and a program for home visits by nurses for first-time mothers. In Illinois' ABE, applicants can choose between a medical-only application and an application for all programs that are included in ABE.

Other states, however, sequence the application process so that questions related to certain programs are asked first and then applicants are given the option to answer additional questions necessary to determine eligibility for other programs. For example, in addition to the PEAK application referenced above, Colorado offers a separate online application through its SBM called Connect for Health Colorado. At the end of the Connect for Health Colorado application, based on the information provided, applicants are informed that they may qualify for other programs and are given an opportunity to answer additional non-medical application related questions to qualify through PEAK. Similarly, California is planning to allow people who complete the Covered California application, which includes Medicaid based on MAGI, CHIP, and marketplace coverage and subsidies, to be automatically transferred in real time to a site that will collect the additional information necessary to complete an application for SNAP and TANF. The Pennsylvania COMPASS application also does this for a number of programs; for example, if a consumer selects only to apply for SNAP, the application will alert the applicant later that he or she may qualify for other benefits like free or reduced-price school meals or Medicaid.

In contrast, some states are planning to allow applicants to choose whether and how to sequence the application process. When Virginia's revised application launches by the end of March 2015, applicants will be able to choose between a MAGI-only path that asks questions necessary to determine Medicaid and CHIP eligibility based on MAGI or a multi-benefit path that asks questions

necessary to determine eligibility for other medical programs, SNAP, TANF, child care services, and energy assistance. Whichever path the applicant chooses, he or she will have the option of continuing down the other path also, with the information from the first path pre-loaded into the second path. Similarly, Kentucky plans to share data between its health-only and multi-benefit applications such that applicants starting in kynect will not have to re-enter data in the multi-benefit application, and vice versa.

Self-service case management features

Self-service case management features allow consumers who have submitted an application to see information about their case, such as the status of their application and the kind, amount, and duration of benefits for which they are eligible. In addition, these features enable clients to take steps to update and maintain their eligibility over time, such as reporting changes in their circumstances that might affect their eligibility and completing renewal or recertification processes online. The features are accessible when the client logs onto his or her secure online account on the client portal. These features give consumers the ability to understand and manage their benefits through a single point of contact. For example, consumers may use these features to provide a single set of updated information that can be evaluated across multiple programs, helping them avoid disruption in benefits and helping states efficiently assess and maintain eligibility across programs over time.

States that have multi-benefit online applications are increasingly implementing self-service case management features to support the same set of programs that are included in the online application. For example, Virginians who log onto their account on the CommonHelp client portal can access “Check My Benefits,” “Report My Changes,” and “Renew My Benefits” features that allow them to see the status of their application or renewal; view information about the benefits for which they have been determined eligible; report changes in their circumstances that may affect their benefits; and use the contact information for their assigned eligibility worker for questions they have about their benefits, next steps they may need to complete, or other eligibility matters. Changes in circumstances that clients report through this feature, such as changes in income or family size, are automatically routed to eligibility workers for appropriate processing across all relevant programs.

Other states are taking similar approaches. Illinois is in the process of implementing a “Manage My Case” module to allow clients who log onto their account on the ABE client portal to view information on the status of their application, upcoming appointments, and the benefits for which they have been determined eligible. This module will also include “Report My Changes” and “Renew My Benefits” capabilities. The Yes New Mexico portal similarly allows consumers who log onto their secure online account to check benefits, view notices, conduct basic plan selection for Medicaid, and process renewals for all of the programs included in the multi-benefit online application (Medicaid, CHIP, TANF, SNAP, LIHEAP, and General Assistance). The Colorado PEAK client portal provides similar functionality and also allows clients who log onto their secure online PEAK account to establish eligibility for additional programs supported by PEAK by submitting minimal additional or updated information, rather than completing a new application from scratch. This includes the ability for someone who already has SNAP or TANF to use the report changes feature to apply for medical assistance.

Other states provide self-service case management features for programs that are not supported by a multi-benefit online application. For example, Idaho provides an online application through its idalink client portal that allows consumers to apply for Medicaid, CHIP, and marketplace coverage, but not for SNAP. However, SNAP clients can log onto their secure idalink account to view their SNAP benefits or complete their SNAP re-evaluation online. Eligibility workers use information clients enter through this feature on the client portal to update health coverage, cash assistance, and child care assistance benefits appropriately as well (see Appendix A for more information about Idaho).

Eligibility Systems and Business Rules Engines

Information collected through application and renewal or other reports of circumstance is entered and stored into eligibility systems. Business rules engines (BREs) work with these systems to automate calculations using logic that reflects program rules to facilitate eligibility determinations. Without BREs, the responsibility of applying all rules falls on eligibility workers. BREs keep health and human services program rules and logic in a module that is separate from the core eligibility system programming. BREs typically include tools to help non-technical users author, model, test, and manage rules. This allows the rules and logic to be updated by people who do not have a lot of technical training and without interfering with the eligibility system's programming. As a result, BREs can lower states' system maintenance costs and help them quickly adapt to policy changes.

Though largely invisible to consumers, BREs can have tremendous impact on the consumer experience because they can dramatically shorten the eligibility and enrollment process, particularly for routine situations. For some programs, BREs can be used to achieve real-time eligibility and enrollment, where consumers are able to receive an eligibility determination and be enrolled in benefits during the same session in which they submitted their application.

For states, BREs in modernized eligibility systems can be used to achieve significant efficiencies throughout the eligibility and enrollment process, automating what would otherwise be manual processes. For example, business rules engines can be programmed with the rules of multiple health and human services programs. They can evaluate information from multiple sources, such as the application the consumer submits and third-party data sources used to verify application information, against each set of rules to establish eligibility for each program. They can also be used to manage workflow, triggering processes for steps such as data verification, follow-up with clients, enrollment in health plans, and issuance of notices and other materials. This automation of routine work can help to standardize the process for more consistent results, reduce the need for duplicative steps and rework, and allow eligibility workers to focus on more complex cases.

With these benefits in mind, states are pushing toward integrated eligibility systems and BREs.

- Idaho implemented a single integrated eligibility system, IBES (Idaho Benefits Eligibility System), in 2009. With ACA implementation, the state has integrated marketplace coverage and subsidies and Medicaid based on MAGI eligibility determinations alongside CHIP determinations. This allows health insurance affordability program determinations to be made without handoffs and creates a platform where business rules for SNAP and TANF can be applied to any applicant. Child care assistance rules are expected to be added to IBES later this year.
- New Mexico implemented a new eligibility system — ASPEN — in June 2014. ASPEN, which uses a BRE to automate eligibility, workflow, and verification rules, currently determines eligibility for

Medicaid, TANF, SNAP, LIHEAP, and some state General Assistance programs. By the next marketplace open enrollment period, it will also determine eligibility for advanced premium tax credits, and future plans may include the integration of additional programs such as WIC and foster care.

- Illinois leveraged other states' investments for its Integrated Eligibility System (IES): much of it is based on Michigan's BRIDGES system, but it also incorporated the business rules engine that New Mexico used for ACA implementation. IES currently processes eligibility determinations for all of the medical, food, and cash assistance programs included in Illinois' multi-benefit online application. The state is considering using the IES for additional programs as well.
- By December 2015, Kentucky plans to integrate business rules for eligibility determinations into its single underlying eligibility system for marketplace coverage and subsidies, all Medicaid programs, TANF, SNAP, and LIHEAP. The BRE will also include rules for pre-determination of WIC eligibility.
- Vermont is adopting a new integrated eligibility system that is intended to process eligibility for 42 programs overseen by the Agency of Human Services, beginning with ACA programs. The first phase of the project focuses on incorporating 27 health-centered programs in the next 18-24 months.
- Oklahoma is in the process of procuring software to support an Oklahoma Benefits System for use by medical, food, cash, child care, and energy assistance programs, as well child welfare and child support programs.

Call Center Technology

Call centers are increasingly becoming a key component of states' efforts to serve consumers. Call center staff can help answer consumers' questions about programs, the eligibility process, and how to use their benefits. They can also help consumers resolve issues and execute various transactions, such as submitting an application, renewing coverage, and reporting changes in circumstances. Call centers can offer convenience for consumers by reducing the need for in-person appointments.

Advanced call center technologies help states manage call volume and wait times and appropriately route calls to the staff with the skills and expertise needed to address the caller's needs. For example, call center technology can keep an inventory of the types of issues that each call center representative is authorized to handle, track when representatives are available to take calls, and automatically transfer callers to an appropriate, available representative. These technologies give states the flexibility to make optimal use of both generalists who can address questions about all programs and specialists in particular programs or types of issues. They also give states the flexibility to route calls wherever representatives are located, allowing for "virtual" call centers. For example, these technologies can make it possible for eligibility workers located in local program offices around the state to serve as a pooled call center resource.

The ACA requires states to offer applications by phone for Medicaid, CHIP, and marketplace coverage and subsidies. To date, most states have focused their call center technology efforts on supporting that requirement, but some are doing so with an eye toward horizontal integration.

- Illinois has established a call center to support Medicaid, CHIP, SNAP, and TANF applicants (the ABE call center), which complements the GetCoveredIllinois marketplace help desk and enables consumers to submit full applications and report changes for all of these programs. Renewals cannot yet be conducted over the phone.
- Pennsylvania operates a virtual call center, which leverages staff located throughout the state to support applicants for its COMPASS programs (Medicaid, CHIP, SNAP, TANF, and LIHEAP). The call center technology routes callers to generalists who are cross-trained for all programs as well as to specialized call centers, such as a Spanish-language center.
- Colorado has developed a similar customer service technical support system that is designed with the flexibility to support decentralized, county-based customer services. When callers use the state Medicaid call center number, the call is routed to the county office where the caller resides. This state system is intended to streamline costs by removing the need for each county to pay for its own call center technology. While the state system is currently being piloted in a single county in support of Medicaid only, the intent is to expand it to additional programs in all counties.
- Kentucky has implemented a single call center infrastructure that supports two different 800 numbers: one that is targeted to kynect clients, staffed by representatives who are trained in health coverage programs only (Medicaid, CHIP, and marketplace coverage); and one that is targeted to Department of Community Based Services (DCBS) clients, staffed by representatives who are cross-trained in Medicaid, SNAP, TANF, and other DCBS programs. Calls can be transferred among representatives as needed, regardless of which 800 number the caller originally used. More complex calls made to either 800 number are routed to DCBS “Tier 2” staff who have more advanced expertise to handle calls for any of the programs.
- Idaho uses a statewide phone system that can quickly connect the appropriate workers by skill set to calling customers. The phone system facilitates what Idaho terms a Universal Workforce where appropriately skilled staff anywhere in the state can connect and resolve issues with any caller. This enables the state to rapidly define work processes and identify skilled staff to respond to emerging needs in hours rather than weeks. Call volumes are more effectively managed, allowing adjustments to routing strategies if call volumes are too high for any skill group. This supports walk-in traffic volume in local offices as well since customers may interact with staff by phone in another, less busy office in the state.

Some states are taking a broader approach to customer service that includes but is not limited to call centers. For example, Vermont is in the process of replacing its Medicaid Management Information System (MMIS). One component of that project centers on developing a contact center intended to manage and report on metrics for contacts with consumers through any means of communication (including telephone, web portal, email, and mail). The agency plans to use this contact center to support well-trained generalists working across all departments and programs within the Agency of Human Services, including health, nutrition assistance, child care, housing, and other human services programs.

Electronic Data Matching

While rules vary across programs, verification of consumer statements about their income and other circumstances is a requirement in the eligibility process for health and human services programs. In some cases, states use electronic data matching to obtain information from trusted data sources

that is then used to verify consumer's circumstances. This electronic data matching for the purpose of verifying eligibility factors can save consumers the hassle, time, and costs of gathering and sending in paper documents that may not be readily available, and for those who apply for multiple programs, electronic data matching can save them from having to provide the same documents multiple times. States benefit from lower costs for storing and manually processing paperwork and overall processing times can be reduced.

Medicaid regulations require states to rely on electronic data matches for verification of circumstances that are relevant to eligibility to the greatest extent possible. In support of that requirement, the Department of Health and Human Services (HHS) has made data from the Department of Homeland Security (DHS), Internal Revenue Service (IRS), Social Security Administration (SSA) and Equifax (a consumer credit reporting agency that provides data that can verify wages of consumers) available through a consolidated data matching interface known as the federal data services hub. For ACA coverage and subsidy applications, states can use this hub to verify information about income, citizenship status, immigration status, incarceration, and consumers' access to other sources of coverage, such as Medicare, TRICARE, and the Department of Veterans Affairs. Most states are using the federal hub in some capacity for ACA eligibility, including Medicaid, CHIP, and marketplace coverage and subsidies; they are not permitted to use the federal hub for other programs.

In some cases, states are implementing new state hubs or consolidated sets of data matching interfaces as an alternative or supplement to the federal hub. For example, New Mexico was approved to use state data matching interfaces to support all programs in their integrated eligibility system, including but not limited to Medicaid, CHIP, and marketplace coverage. The state is working on implementing its own state data services hub, which is scheduled to launch in time for the marketplace open enrollment period in fall 2015.

States have also focused on making better, more efficient use of existing data matching interfaces. For example, Illinois is in the process of integrating all of its existing data matching interfaces into its new Integrated Eligibility System (IES) so that workers do not have to access multiple systems during the verification process. The IES has a unified page that allows workers to see all available verification data across all relevant programs and decide whether the relevant eligibility factors have been sufficiently verified. Verification rules are also being programmed into the IES business rules engine to automate the process of determining when data match information can substantiate consumer statements about their circumstances and when additional documentation is required. This automation is intended to increase the state's ability to establish eligibility in real time, beginning with Medicaid and CHIP.

Document Imaging and Management

States can use document imaging and management systems to support streamlined document processing among benefit programs. These systems can scan, store, identify, and route documents received from consumers, including paper applications and paper copies of documents that verify their circumstances, such as pay stubs and birth certificates. For example, a SNAP eligibility worker may receive a paper copy of pay stubs from a consumer who is applying for SNAP. The worker can scan and store a copy of these documents in the system as part of the consumer's case. If the same consumer later applies for Medicaid, the Medicaid eligibility worker can pull up the pay stubs from

the document management system to see if the information is current enough and reasonably compatible with the income the consumer reported on the Medicaid application. If so, the eligibility worker does not have to seek additional proof from the consumer. These systems make it easier for multiple workers to be involved in a single case as needed over time, helping states accomplish integrated eligibility across programs and handoffs among different programs or units of workers, such as call center representatives and workers in local eligibility offices. States can also use document imaging and management systems to generate and store communications with consumers, such as notices of action and requests for information.

Some states have made it possible for applicants to upload and view documents through the client portal. Currently, those documents often go straight into the case management system, but states increasingly are looking to implement more document management systems that offer greater functionality to make it easier for workers to find and share information. For example, Illinois has plans to enhance documentation management through high-speed scanning capabilities that take advantage of bar code technology, helping the state implement a centralized incoming mail facility and move toward the elimination of paper in program offices. Virginia is also implementing a new document management system. By August 2015, it plans to have all records electronically accessible, including previously submitted documents for existing cases.

Pennsylvania is in the process of implementing a new centralized document imaging system that will be accessible to state and county eligibility workers. The state has opted to implement this system first for its child support program. Because Pennsylvania plans to leverage the system to support Medicaid program eligibility, it obtained approval to utilize enhanced federal funds through the A-87 cost allocation waiver. The state plans to pilot the system for child support in three counties in mid-2015, with the goal of implementing statewide for child support, Medicaid, and CHIP by the end of 2015, and additional programs like SNAP and TANF over time.

Data Management and Analytics

States are examining ways to make better use of health and human services data to improve program operations and outcomes for clients. Data management and analytic tools allow states to merge data from multiple sources (e.g., case records and claims databases) and analyze it at the case, program, or population level to support better decision-making. Case workers can view data for an individual case across all programs and over time to assess and meet clients' needs. Program planners can take historical, current, and predictive views of program operations to identify trends in program performance, forecast future program needs, and model the effects of potential policy changes. For example, data analytics can help states monitor seasonal, regional, or population-based variations in program participation and identify targets for additional outreach, augment staffing to handle higher volumes of applications, or otherwise adjust program planning.

Several states indicated that data management and analytics would be a focus of future efforts.

- To better monitor and report on ACA eligibility and enrollment, Colorado has begun implementing a data analytics platform that will pull data from a wide array of health and human services programs. The first use of the platform is a Department of Health Care Policy and Financing Executive Analytics Dashboard that monitors ACA performance metrics such as number of PEAK accounts created, number of people determined eligible and ineligible, ineligibility reasons, how

applications are submitted (online, phone, mail, in person), and application processing times (including real time). This Dashboard has improved the state's ability to meet reporting requirements while lowering the costs and redundancy of manual, error-prone processes that would otherwise be required. Over time, Colorado intends to expand the use of this platform to do similar performance monitoring for other programs, inform executive decision-making in the state, and improve case workers' ability to serve consumers across programs.

- Pennsylvania is exploring options for enhancing its analytics of unstructured data housed in a data warehouse that serves all programs in the Department of Human Services and has been in place since the early 2000s.
- Kentucky has implemented a large data warehouse that links individuals' records across health care programs through a master data management system. The state has applied for funding to support expanding this warehouse to include an all payers claims database so it can match clinical and claims data in an effort to identify gaps in coverage and services and improve program coordination. Once Kentucky's eligibility system and business rules engine have fully integrated marketplace coverage, all Medicaid programs, CHIP, TANF, SNAP, LIHEAP, and WIC in December 2015, the data warehouse will also link across all of those programs.
- New Mexico has implemented an enterprise master client index which allowed the state to compare client records across different systems and link them to track individual cases. This allowed the state to merge seven distinct health and human services program databases into a single repository representing 2 million unique individuals. The state plans to leverage this repository across multiple agencies, which will launch in June 2015, to produce analytics on how people use services across the state and over time.

Mobile Tools

States are in the early stages of exploring how mobile tools can help consumers understand, access, use, and maintain their benefits. Some states are starting with optimizing their client portals for tablets. A small number have developed or are exploring mobile "apps." For example, Kentucky has a mobile app that allows users to access an eligibility screener, find in-person assistance, and learn about health coverage options. The state is in the process of expanding the mobile app's functionality to allow consumers who have already established a user account through kynect to view some parts of their application, upload documents, and make some case changes. Over time, Kentucky would like to provide similar mobile tools for other non-health programs. Colorado has designed the *PEAKHealth* mobile app targeted to the Medicaid and Child Health Plan *Plus* population. It is available in English and Spanish and provides users with a dynamic provider directory, benefit information, real time digital medical ID cards, and the ability to update eligibility and account information such as phone number, mailing address, email, and income, including uploading paystubs into the Electronic Document Management System. Colorado is exploring developing a suite of connected and similar apps for other programs, such as SNAP.

Other states are looking for ways to incorporate mobile tools into their workflow. For example, Oklahoma is exploring the use of iPads as kiosks in their Department of Human Services offices for use in the programs they administer, including Medicaid, SNAP, TANF, and LIHEAP. Roving workers would help people in the waiting rooms use the kiosks to conduct business, such as taking and submitting a photo of required verification documents, without having to wait for an appointment with a worker.

Common Themes

The examples highlighted above illustrate the variety of technology approaches states are taking toward horizontal integration. Regardless of these variations, however, some common themes have emerged.

Governance Matters

Most states featured in this brief emphasized the importance of leadership and governance in their efforts to pursue technology features that will support horizontal integration. For example, Kentucky's technology efforts are driven at the Cabinet for Health and Family Services level, with the input and oversight of staff from all state health and human services programs within the cabinet, including Medicaid, public health, SNAP, TANF, child care subsidies, and energy assistance. Virginia's vision is to extend the technology platform that supports Health and Human Resources agencies to promote increased interoperability throughout the Commonwealth. To achieve that vision, the program relies on a close collaboration across several Secretariats, including HHR, Technology, Transportation, and General Services. Oklahoma's governance structure for the Oklahoma Benefits System (Deliver Interoperable Solution Components Using Shared Services (DISCUSS)) is chaired by the Deputy Secretary of Health and Human Services (HHS); members include agency heads or their designees for all HHS programs. Illinois has established an Eligibility Modernization Oversight Group, an interagency collaborative workgroup with members from the Department of Healthcare and Family Services, Department of Human Services, and the Illinois Health Insurance Marketplace.

Don't Forget Business Process Reengineering

Business process reengineering involves identifying, analyzing, and redesigning workflows to improve productivity and other performance measures. Ideally, technology projects occur after business process reengineering is complete, so that technology supports the new workflows and expectations for how staff will be deployed and trained, how tasks are to be managed, business that should occur online, by phone, or in local offices, and other key processes.

Some states were able to use business process reengineering to drive their technology efforts in support of horizontal integration.

- Virginia programmed its new Virginia Case Management System (VaCMS) based on a business process reengineering project the state undertook several years ago but that was stopped due to a lack of funding. The opportunity presented under the recent federal initiatives allowed Virginia to use the BPR artifacts as a model for the new case management system.
- New Mexico undertook a significant business process reengineering effort prior to the implementation of its new integrated eligibility system, and designed that system to support its new process model.
- Idaho went through an extensive business process reengineering exercise in 2007-2009, prior to replacing its legacy eligibility system. This reengineering resulted in a family-centric "single touch" approach under which the state strives to resolve client issues, including eligibility determinations, at the first point of contact with the client. A universal workforce approach to case management, which puts a decision-maker at every point of client contact, supports this

“single touch” approach. Reengineering continues to drive Idaho toward program integration and helps them decide which technology solutions are needed.

- Illinois, which already had a unified case management approach through which individual staff members worked on multiple programs, recently implemented a uniform business process in all local offices, allowing for movement of cases among workers, movement of work among offices to balance workloads and address areas of high need, and development of standard business metrics. This new business process was made possible by the workflow engine in its new Integrated Eligibility System.

Others were not able to complete business process reengineering in advance, but have still found benefits from engaging in it after or alongside their technology efforts in order to optimize the value and success of their technology investments.

- Pennsylvania is moving toward more centralized processing with the goal that any given case can be worked on by a variety of workers across counties; a LIHEAP application, for example, could be processed in multiple sites throughout the state depending on current workload volume.
- Vermont’s Agency of Human Services oversees a broad range of health, nutrition assistance, child care, housing and other human services programs as well as the Department of Corrections. The agency engaged in business process reengineering in 2014 to reorganize its efforts around the customer, rather than various funding streams, and become “an agency of one” that helps people achieve better life outcomes. Each business process flow that emerged from the effort has its own “owner,” a single person who is responsible for reviewing and approving the work being done across all technology projects throughout the agency to ensure technology supports the desired business process consistently and efficiently. This approach amounts to a new governance structure that is driving the state toward using the open, service-oriented architecture that it adopted for its marketplace as a platform to serve all programs and departments within the agency. Integrated case management is at the center of the architecture, with the goal of having a master case for all households and a master case manager responsible for developing and maintaining a master case plan that coordinates work to be done across all programs.

Carefully Consider Cost Allocation Options

States are using a blend of funding streams for their horizontal integration efforts, including marketplace, Medicaid, and human services program funds; federal and private grant funds; and state funds. These funds not only come from different sources, but are available for different purposes and have different restrictions and timeframes for use. States that are trying to maximize value from these funds are taking a close look at their methods for cost allocation, including careful examination of the types of work they are doing, how to properly categorize it (e.g., eligibility versus operations), how to quantify it (e.g., based on how many applications are processed versus the eligibility results from the applications), and which programs benefit from it. For example, states considering integrated eligibility processes for Medicaid and marketplace coverage and subsidies may explore allocating a portion of the costs of marketplace cases to Medicaid, based on the requirement that an applicant be determined ineligible for Medicaid before he or she can be determined eligible for a marketplace subsidy.

Optimize Use of the Cost Allocation Waiver

To meet the demanding timeframes and requirements of ACA implementation, states have taken phased approaches to technology adoption, prioritizing Medicaid and marketplace in the early stages. Because enhanced federal funding opportunities were originally scheduled to expire in December 2015, states focused on horizontal integration efforts that could be accomplished within this timeframe.

Now that the enhanced Medicaid funding for building or upgrading eligibility systems is available on a permanent basis and the cost allocation waiver is available through December 2018, states can reconsider their technology adoption plans. States are considering those options now. Several states are still aiming to complete work by December 2015 and do not expect the extension to affect their rollout. Others may decide to take advantage of the additional breathing room to finish the efforts already underway. Some may decide to expand their horizontal integration efforts by leveraging technologies already put in place for Medicaid. Some may reassess whether planned projects may qualify for the extended cost allocation waiver or begin to plan for additional solutions that did not seem as feasible or high a priority under the shorter timeframes, such as mobile technologies, additional verification interfaces, more robust call center capabilities, and data analytics to make it easier to monitor and improve performance across programs. Given the continued time-limited nature of the cost allocation waiver, states may also decide to accelerate their horizontal integration efforts, including the possibility of implementing some advances in human services programs even before making changes to their Medicaid systems, as Pennsylvania is doing with its document imaging system (described above). In any case, states will need to carefully consider their cost allocation strategies to get the best value for their investments.

Look Ahead to Advance Performance Measurement and Improvement

Once mature, the technologies that states are adopting will be useful in building the data and analytics capacity for assessing how horizontal integration efforts are working and where further improvements can be made. For example, states will be able to assess whether their efforts are resulting in higher joint participation rates, lower “churning” of people on and off of benefits, and reduced duplication of effort and associated costs across programs. They will also be able to get a more complete picture of individuals’ and families’ needs for and use of programs over time, including recognition of shifts as economic and demographic realities in the state change. States increasingly will have the tools to assess program performance on measures such as access, participation, retention, and customer satisfaction. They will be able to assess with greater speed and precision how long various steps in the eligibility and enrollment process take for consumers and workers, and at which points consumers are more likely to drop out of applying for or retaining benefits. These assessments can help states adjust their approaches for better results and plan for future policy, operational, and technology changes.

Conclusion

With the passage of the Affordable Care Act, states have additional incentives and opportunities to adopt technologies that make it easier for individuals and families to connect to the health and human services programs for which they are eligible. A variety of technology solutions are available to meet states’ needs, regardless of each state’s prior program integration efforts or decisions about Medicaid expansion and marketplace implementation. These solutions can help states improve

their operating efficiencies while allowing them to better meet the needs of their constituents, all while maximizing federal dollars.

Appendix A: State Spotlights

State Spotlight: Illinois

Illinois has taken a comprehensive and cross-agency approach to its horizontal integration efforts. Its Integrated Eligibility System (IES) is designed to process determinations and manage eligibility for medical programs (including Medicaid, CHIP, and other state-sponsored programs), SNAP, and TANF, with the possibility of expanding to other state programs in the future. Illinois specifically designed the IES to be interoperable with a State-based Marketplace in the event that the state should adopt that model in the future.

Clients experience this integrated eligibility system via a new multi-benefit online application, Application for Benefits Eligibility (ABE). Enhancements underway will soon allow clients to manage their benefits for all of the ABE programs online. The state's GetCoveredIllinois.gov portal directs clients who are interested in health coverage to either ABE (for those who are likely eligible for Medicaid, CHIP, or other state-sponsored health programs) or to the FFM (for those who are likely eligible for marketplace coverage and subsidies).

State workers also experience an integrated process. Illinois is in the process of integrating all existing verification interfaces into the IES so workers don't have to access multiple systems during the verification process. Additionally, verification rules are being programmed into the IES to promote automation and increase real-time eligibility determination. Illinois has also implemented a uniform business process in all local offices and has developed standard business metrics.

These efforts are being directed by the Eligibility Modernization Oversight Group (EMOG), an inter-agency collaborative workgroup with membership from the Department of Healthcare and Family Services, the Department of Human Services, and the Illinois Health Insurance Marketplace.

State Spotlight: Kentucky

Kentucky, which took an integrated approach to eligibility and enrollment across health and human services programs prior to the ACA, is actively pursuing its strategy to return to a single, integrated eligibility system. Since ACA implementation in 2013, Kentucky has operated its new Health Benefit Marketplace and Medicaid eligibility and enrollment system (HBE/E&E) alongside its 20-year-old integrated legacy system for Medicaid, CHIP, SNAP, and TANF. By the end of 2015, the state plans to integrate SNAP, TANF, and LIHEAP into the new HBE/E&E. The BRE will also include rules for pre-determination of WIC eligibility.

Kentucky has implemented two online applications that refer clients between them and will both ultimately be supported by the HBE/E&E. A health-only application available through the kynect portal provides access to Qualified Health Plans and subsidies as well as Medicaid based on MAGI and CHIP, while a multi-benefit application to be launched on a separate portal that is under development will provide access to Medicaid, CHIP, TANF, SNAP, child care subsidies, LIHEAP, and WIC. Data will be shared between these applications, such that applicants starting in kynect will not have to re-enter data in the multi-benefit application, and vice versa.

Data analytics are a central part of Kentucky's plans to evaluate its integrated approach to coverage. The HBE includes a large data warehouse that links individuals' records across programs through a master data management system. The state has applied for funding to support development of an all payers claims database so it can match clinical and claims data to look at people as a whole in an effort to identify gaps and improve program coordination.

Kentucky's technology integration efforts are driven at the Cabinet for Health and Family Services level, with the input and oversight of staff from all state health and human services programs within the cabinet, including Medicaid, CHIP, public health, SNAP, TANF, child care subsidies, and energy assistance. At the foundation of these efforts is Kentucky's Quality Health Initiative Architecture, a framework that guides the development of technology projects across programs and throughout the state.

State Spotlight: Idaho

Idaho seized upon the ACA as an opportunity to continue and strengthen its horizontal integration approach. Having implemented a single integrated eligibility system (Idaho Benefit Eligibility System, or IBES) in 2009, Idaho opted to integrate the MAGI eligibility rules for Medicaid, CHIP, and its marketplace coverage and subsidies into that system, along with the business rules for SNAP, TANF, and child care.

One of the state's priorities was a verification aggregator called eVerif-I, a stand-alone tool that allows workers to see a comprehensive view of available verifications. This tool pulls information from the IRS, Social Security Administration, the state Department of Labor, and state child support databases. This allows workers to use information already on record for other programs to determine eligibility, pursuant to data sharing rules.

Idaho has also made significant investments in cloud-based call center technology. Consumers are able to complete a multi-benefit application by phone, with their telephonic signature stored electronically. Callers are routed to available workers whose skills match the caller's needs. If call volumes cannot be managed by the two centralized call centers, calls can also be routed to workers in local eligibility offices around the state.

Idaho's technology approach was driven by an extensive business process reengineering exercise it undertook between 2007 and 2009, before it replaced its legacy eligibility system with IBES. This reengineering resulted in a family-centric "single touch" approach under which the state strives to resolve client issues, including eligibility determinations, at the first point of contact with the client. A universal workforce approach to case management, which puts a decision-maker at every point of client contact, supports this "single touch" approach. Reengineering continues to drive Idaho toward program integration and helps them decide which technology solutions are needed.

Appendix B: State Summaries

State	Marketplace Model ¹⁶	Medicaid Expansion ¹⁷	Medicaid Eligibility System Modernization ¹⁸	Client Portals and Eligibility Systems
Alabama	FFM	Not adopting the Medicaid expansion at this time	Replacement	<ul style="list-style-type: none"> • myalabama.gov (online portal for Alabama services) • mydhr.alabama.gov (online application for food assistance) • insurealabama.adph.state.al.us (online application for Medicaid & CHIP) • Centralized Alabama Recipient Eligibility System (CARES) (replacement eligibility system that currently supports Medicaid and CHIP; food, and cash, and child care assistance are to be supported in future phases)
California	SBM	Adopted the Medicaid expansion	Replacement	<ul style="list-style-type: none"> • coveredca.com (online portal for SBM) • California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) (eligibility and enrollment system for MAGI Medicaid and SBM, accessible via coveredca.com) • benefitscal.com (online portal that directs users to the appropriate Statewide Automated Welfare System (SAWS), based on county of residence) • mybenefitscalwin.org (online application for medical, food, and cash assistance in the 18 counties using the CalWIN SAWS) • c4yourself.com (online application for medical, food, and cash assistance in the 39 counties using the C-IV SAWS) • dpssbenefits.lacounty.gov (online application for medical, food, and cash assistance in Los Angeles County) • LEADER Replacement System (LRS) (replacement eligibility system for Medicaid, food, and cash assistance for the C-IV SAWS currently in use in 39 counties and the SAWS system currently in use in Los Angeles County)

Colorado	SBM	Adopted the Medicaid expansion	Modification	<ul style="list-style-type: none"> • connectforhealthco.com (online portal for SBM) • coloradopeak.force.com (online application for medical, food, and cash assistance) • Colorado Benefits Management System (CBMS) (modified eligibility system that supports medical, food, and cash assistance)
Idaho	SBM	Not adopting the Medicaid expansion at this time	Modification	<ul style="list-style-type: none"> • yourhealthidaho.org (online portal for SBM) • idalink.idaho.gov (online portal for medical, food, cash, and child care assistance) • Idaho Benefits Eligibility System (IBES) (modified eligibility system that supports medical, food, cash, and child care assistance)
Illinois	FFM Partnership Model	Adopted the Medicaid expansion	Replacement	<ul style="list-style-type: none"> • getcoveredillinois.gov (online portal that directs users to the appropriate online application (ABE or healthcare.gov), based on screening questions) • abe.illinois.gov (Application for Benefits Eligibility (ABE), an online application for medical, food, and cash assistance) • Integrated Eligibility System (IES) (replacement eligibility system that supports medical, food, and cash assistance)
Kentucky	SBM	Adopted the Medicaid expansion	Replacement	<ul style="list-style-type: none"> • kynect.ky.gov (online portal for SBM) • prd.chfs.ky.gov/SNAPPrescreen/SNAPLanding.aspx (online application for SNAP) • Health Benefit Exchange Eligibility and Enrollment system (HBE/E&E) (replacement eligibility system that supports Medicaid and SBM; SNAP, TANF, and additional human services programs are to be supported in future phases)
New Mexico	SBM*	Adopted the Medicaid expansion	Replacement	<ul style="list-style-type: none"> • yes.state.nm.us (online application for medical, food, cash, and energy assistance) • bewellnm.com (online portal for SBM) • Automated System Program and Eligibility Network (ASPEN) (replacement eligibility system that supports medical, food, cash, and energy assistance)

Oklahoma	FFM	Not adopting the Medicaid expansion at this time	Modification	<ul style="list-style-type: none"> • mysoonercare.org (online application for Medicaid) • okdhslive.org (online portal for Medicaid, SNAP, child care, school meals, and WIC) • OK Benefits (currently in procurement: replacement eligibility system for medical, food, cash, child care, and energy assistance, as well as child welfare and child support)
Pennsylvania	FFM	Adopted the Medicaid expansion**	Modification	<ul style="list-style-type: none"> • compass.state.pa.us (online application for medical, food, cash, child care, and energy assistance) • Electronic Client Information System (eCIS) (modified eligibility system that supports medical, food, and cash assistance)
Vermont	SBM	Adopted the Medicaid expansion	Replacement	<ul style="list-style-type: none"> • healthconnect.vermont.gov (online portal for SBM) • mybenefits.vt.gov (online application for food, cash, and energy assistance) • Integrated Eligibility Solution (currently in procurement: replacement eligibility system to support medical, food, cash, energy, and housing assistance)
Virginia	FFM	Not adopting the Medicaid expansion at this time	Replacement	<ul style="list-style-type: none"> • coverva.org (online portal that directs users to the appropriate online application (CommonHelp or healthcare.gov), based on screening questions) • commonhelp.virginia.gov (online application for medical, food, cash, child care, and energy assistance) • VaCMS (replacement eligibility system that supports Medicaid and CHIP; food, cash, and energy assistance programs are to be supported in future phases)

* For Plan Year 2015, the state's Marketplace will be using the FFM's information technology platform for eligibility and enrollment functions.

** Pennsylvania has an approved Section 1115 waiver for the Medicaid expansion. Coverage under the Pennsylvania waiver went into effect on January 1, 2015, but the newly elected governor has stated he will transition coverage to a state plan amendment.

Appendix C: Standards and Conditions for Modernized Medicaid Systems

To qualify for enhanced federal funding, states' modernized Medicaid IT systems must meet seven conditions and standards:

1. **Modularity.** Systems should have an open, reusable architecture; expose application programming interfaces; and use a business rules engine to separate business rules from core programming. Modularity is important to ensuring that states can readily change, maintain, integrate and interoperate their systems.
2. **MITA alignment.** Systems should be consistent with the Medicaid Information Technology Architecture (MITA) initiative, which provides a common framework for states, the federal government, and stakeholders to improve the administration and operation of the Medicaid program.
3. **Industry standards alignment.** Systems should comply with industry standards such as standards for security, privacy, and transactions under the Health Insurance Portability and Accountability Act. Systems should also comply with standards developed pursuant to Section 1561 of the ACA, which requires that ACA enrollment systems be designed with the capacity to integrate additional health and human services programs.¹⁹
4. **Leveragability.** Systems should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states. This condition allows states to benefit from the experience and investments of other states.
5. **Business results.** Systems should support and enable effective and efficient business processes to produce desired business outcomes, such as accurate and timely eligibility processing. Systems should be highly automated and meet established performance standards.
6. **Reporting.** Systems should produce accurate data that are necessary for oversight, administration, evaluation, integrity, and transparency.
7. **Interoperability.** Systems should allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.²⁰

¹ Gregory Mills, Jessica F. Compton and Olivia Golden, "Assessing the Evidence about Work Support Benefits and Low-Income Families: Rationale for a Demonstration and Evaluation," Urban Institute, February 2011, <http://www.urban.org/UploadedPDF/412303-Work-Support-Benefits.pdf>.

² Martha Heberlein, Tricia Brooks, Joan Alker, Samantha Artiga and Jessica Stephens, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Georgetown Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured, January 2013, <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf>.

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- ³ Laura Wheaton, Victoria Lynch, Pamela Loprest and Erika Huber, “Joint SNAP and Medicaid/CHIP Program Eligibility and Participation in 2011,” Urban Institute, September 2014, <http://www.urban.org/UploadedPDF/413246-Joint-SNAP-and-Medicaid-CHIP-Program-Eligibility-and-Participation-in-2011.pdf>.
- ⁴ Laura Wheaton, Victoria Lynch, Pamela Loprest and Erika Huber, “Joint SNAP and Medicaid/CHIP Program Eligibility and Participation in 2011,” Urban Institute, September 2014, <http://www.urban.org/UploadedPDF/413246-Joint-SNAP-and-Medicaid-CHIP-Program-Eligibility-and-Participation-in-2011.pdf>.
- ⁵ Federal Register: Volume 77, Number 57, March 23, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>; “Guidance for Exchange and Medicaid Information Technology (IT) Systems,” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, May 2011, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaidguidance.pdf>.
- ⁶ Federal Register: Volume 76, Number 75, April 19, 2011, <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>.
- ⁷ Letter from Center for Medicare and Medicaid Services, October 28, 2014, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-90/10-funding-extension.pdf>.
- ⁸ Stan Dorn, Julia Isaacs, Sarah Minton, Erika Huber, Paul Johnson, Matthew Buettgens and Laura Wheaton, “Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act,” Urban Institute, December 2013, <http://www.urban.org/UploadedPDF/413028-Overlapping-Eligibility-and-Enrollment-Human-Services-and-Health-Programs-Under-the-Affordable-Care-Act.pdf>; Dottie Rosenbaum, Shelby Gonzales, Danilo Trisi, “A Technical Assessment of SNAP and Medicaid Financial Eligibility Under the Affordable Care Act (ACA),” Center on Budget and Policy Priorities, June 6, 2013, <http://www.cbpp.org/cms/?fa=view&id=3939>.
- ⁹ For more information about the interplay of horizontal integration and health reform, please refer to “Improving the Delivery of Key Work Supports: Policy & Practice Opportunities at A Critical Moment,” Center on Budget and Policy Priorities, February 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3408>.
- ¹⁰ “OMB Circular A-87 Revised,” Office of Management and Budget, Rev. May 10, 2004, http://www.whitehouse.gov/omb/circulars_a087_2004.
- ¹¹ Letter from U.S. Department of Health & Human Services and U.S. Department of Agriculture, August 10, 2011, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Cost-Allocation-IT-Systems.pdf>.
- ¹² The business processes and technical services that could qualify under the A-87 cost allocation waiver include, but are not limited to, client portals, master client index, business rules engine and operating system, various interfaces, enterprise service bus, data warehouse, workflow management tools, notices, customer services technical support, automated account creation and case notes, identity management, document imaging, privacy and security controls, business intelligence, analytic tools, and infrastructure and data center hosting. For federal guidance on the waiver, refer to Letter from U.S. Department of Health & Human Services and U.S. Department of Agriculture, January 23, 2012, http://www.acf.hhs.gov/sites/default/files/ocse/smd_1_23_12.pdf. For more information about the cost allocation waiver and how states can use it to promote horizontal integration, please refer to “A-87 Exception Toolkit for Human Services Agencies: Description of the Exception and Recommendations for Action,” APHSA National Workgroup on Integration, Finance Subcommittee, Rev. July 2014, http://www.aphsa.org/content/dam/aphsa/pdfs/NWI/Revised%20A-87_Exception_Toolkit%207-11-14.pdf.
- ¹³ Letter from Center for Medicare and Medicaid Services, October 28, 2014, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-90/10-funding-extension.pdf>.
- ¹⁴ Center for Medicare and Medicaid Services, October 28, 2014.
- ¹⁵ “Online Services for Key Low-Income Benefit Programs: What States Provide Online with Respect to SNAP, TANF, Child Care Assistance, Medicaid, and CHIP,” Center on Budget and Policy Priorities, revised March 18, 2015, <http://www.cbpp.org/cms/index.cfm?fa=view&id=1414>.

¹⁶ Marketplace models include State-based (SBM), Federally-facilitated (FFM), and working in partnership with the Federal Marketplace (FFM Partnership Model). “Medicaid and CHIP Marketplace Interactions,” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, as of November 6, 2014, <http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/medicaid-chip-marketplace-interactions.html>.

¹⁷ “Status of State Action on the Medicaid Expansion Decision,” Kaiser Family Foundation, as of March 6, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

¹⁸ “Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist,” U.S. Government Accountability Office, GAO-15-169, December 2014.

¹⁹ Section 1561 of the Affordable Care Act.

²⁰ “Enhanced Funding Requirements: Seven Conditions and Standards,” Department of Health and Human Services, April 2011, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>.