How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation

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Executive Summary

Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) expands Medicaid to cover adults and children with incomes at or below 138 percent of the federal poverty level (FPL), making millions of Americans eligible for the first time. The legislation also creates new federal subsidies to help households with incomes up to 400 percent of FPL afford health insurance. Filed in-person, online, by phone, and by mail, applications for all of these programs will be decided by a single eligibility system in each state, based whenever possible on data matches with tax records, quarterly wage data, and other sources of information. Only if such matches fail to qualify consumers for help will they be asked for documentation.

To support this new system, the federal government is providing significant support for state development of information technology (IT). Until 2015, Medicaid and other federal grants will pay more than 90 percent of the cost of eligibility-related IT investments. To qualify for this funding, eligibility systems must meet federal standards for a seamless, first-class consumer experience that typically makes eligibility determinations in "real time," while consumers are waiting.

The ACA's combination of broad eligibility, streamlined enrollment, and a legal responsibility for individuals to obtain health coverage should result in the country's most widely-used program of need-based assistance. Human services programs can take advantage of this new infrastructure to reduce burdens on families, increase access to critical work supports, reduce administrative costs, and improve the accuracy of eligibility determination. They can do this by providing benefits such as the Supplemental Nutrition Assistance Program (SNAP, formerly called "food stamps"), child care subsidies, or cash assistance based on the findings of ACA's eligibility system. That approach could reduce the need to process largely redundant human services applications from people for whom health coverage programs have already determined key facts relevant to eligibility.

Once consumers complete health coverage applications, they could be offered the choice of having their information shared with other state agencies to qualify for additional benefits. If consumers consent, both the information they provide on the health application and any verification obtained by the health program would be conveyed electronically to human services programs. The latter would immediately begin determining eligibility. Clients would be asked for further information only when data from the health programs proved insufficient to qualify them for human services. Further streamlining would result if human services programs changed their eligibility rules to fit the data received from health coverage programs so that, as a general rule, no additional information would be needed to determine whether someone qualifies for human services.

It may be easier to take this approach with subsidized child care, Temporary Assistance for Needy Families (TANF), the Low-Income Home Energy Assistance Program (LIHEAP), and other benefits than with SNAP, given the latter program's federal statute. However, even with SNAP, the policy discussed here might qualify as a pilot or demonstration project. Congress

could also modify SNAP eligibility rules in the forthcoming farm bill, slated for action by the end of 2012. In any case, clear federal guidance about policy options for human services programs would help state officials move forward in connecting with the ACA's eligibility infrastructure.

Such connections could also help Medicaid enroll qualified individuals based on the eligibility records of human services programs. Reaching nearly 45 million low-income people, SNAP is a particularly promising source of information that could qualify consumers for Medicaid. Using data matches between Medicaid and SNAP files to enroll adults into Medicaid could reduce the administrative burden states face in coping with the forthcoming surge in Medicaid applications while quickly providing millions of uninsured adults with coverage.

Human services programs also have a time-limited opportunity to modernize their own eligibility-related IT. Medicaid, with enhanced federal funding, can pay the full cost of necessary improvements to computer systems that are used by both Medicaid and other programs. This departs from the usual practice of allocating costs across all benefiting programs. The temporary availability of federal funding far above the levels that are normally offered to human services programs provides a significant incentive for states to move ahead quickly in developing integrated and updated systems. Human services programs that do not share eligibility systems with Medicaid might qualify for this enhanced federal funding by pursuing efforts, described earlier, to link health programs with information in the files of human services programs about income and other facts potentially relevant to eligibility for health coverage. If human services programs instead continue to use current IT, they will pay a larger share of such IT's operating costs as Medicaid's eligibility work moves to new systems. Human services programs that do not modernize in tandem with Medicaid could thus face serious fiscal risks. To avoid those risks while maximizing IT gains, human services agencies need to quickly contact their Medicaid counterparts to gain a "seat at the table" in planning the ACA's infrastructure for eligibility determination.

As states establish new, streamlined avenues for seeking health coverage electronically and telephonically, it will be important to ensure that social services offices remain available as entryways to health coverage. While some consumers prefer online or telephone applications, others value in-person contact. If health applications are removed from the daily work of social services agencies, families seeking multiple benefits may need to provide the same information to multiple programs. Household burdens would increase, impairing enrollment. If instead such agencies retain their Medicaid portfolios and incorporate the ACA's new data-matching tools into eligibility determination for human services programs, important gains in such programs' efficiency, program integrity, and access to benefits could result.

The forthcoming expansion of Medicaid coverage could also help human services programs achieve their own core goals by increasing the number of low-income parents with coverage, thereby improving their access to necessary health care. When parents receive treatment for depression or other illness, they are more likely to gain and keep employment, and their children are more likely to thrive. Human services programs and advocates could thus engage Medicaid programs in structuring both enrollment and care delivery to maximize troubled parents' ability to obtain services that promote self-sufficiency and children's healthy development.

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Glossary

The audience for this paper includes readers who may be new to health issues and the data-driven eligibility determination process contemplated by the Patient Protection and Affordable Care Act (ACA). While the terms explained here are usually defined in the body of the paper, some readers may find it helpful to have this list in one place.

» **Advance Planning Document (APD):** A document that a state presents to obtain federal approval of the state's IT development plan.

» **Business rules:** Rules that determine how computer systems will process information.

» **CHIP:** The Children's Health Insurance Program.

» **CMS**: The Centers for Medicare and Medicaid Services, the HHS entity that administers Medicare, Medicaid, and CHIP. CMS also provides federal oversight and direction for exchanges.

» **Cost allocation principles**: Rules for apportioning among multiple programs costs that benefit more than one program.

» **Data sharing agreement**: An agreement between government agencies about the terms and conditions for exchanging data.

» **Dynamic forms or dynamic web sites:** An approach that varies the form presented to the end-user based on information already provided by the end-user or other data.

» **Exchanges**: Health insurance exchanges, which operate in each state and perform multiple functions, including determining eligibility for insurance affordability programs, certifying participating health plans for compliance with federal requirements, and providing consumers with "one stop shopping" as they enroll into health coverage.

» **Federal data hub**: A federally administered service that will provide insurance affordability programs with information from multiple federal sources.

» **Horizontal integration**: Connecting different programs that serve a common or overlapping population—for example, Medicaid, SNAP, TANF, and subsidized child care.

» **Insurance affordability programs**: Medicaid, CHIP, and new federal subsidies to help low-and moderate-income people purchase coverage in the exchange.

- **MAGI**: Modified adjusted gross income, which is used to determine eligibility for insurance affordability programs under the ACA. With MAGI, federal individual income tax rules determine net income and household composition.

- **National Information Exchange Model (NIEM)**: A model for exchanging information between different, even incompatible computer systems, through which they communicate using a common definition and structure for key data elements, such as name and date of birth.

- **Patient Protection and Affordable Care Act (ACA)**: Federal health reform legislation.

- **Pre-populating forms**: A government agency's presentation to the consumer of a form that is partially or fully completed based on information available to the agency.

- **Rules engine**: A repository of business rules that drives the operation of a computer system.

- **Shared eligibility service or "eligibility service"**: In each state, a single system that helps determine eligibility for multiple insurance affordability programs.

- **IT**: Information technology.

- **SNAP**: The Supplemental Nutrition Assistance Program, the program formerly known as "Food Stamps."

- **TANF**: Temporary Assistance for Needy Families, which replaced Aid to Families with Dependent Children (AFDC). TANF provides a range of services to needy families. However, as used in this paper, the term primarily refers to cash assistance.

- **Vertical integration**: Connecting programs that provide a similar benefit to populations with different income levels—for example, Medicaid, CHIP, and subsidies in the exchange.

How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation

Introduction

The Patient Protection and Affordable Care Act (ACA)[1] seeks to greatly reduce the number of uninsured Americans. To that end, federal lawmakers applied many innovative strategies for using data to simplify and streamline eligibility determination and enrollment into subsidized health coverage. To implement those strategies, many state Medicaid programs will need to completely overhaul their eligibility systems. Helping states transition to this new data-driven approach, the Centers for Medicare and Medicaid Services (CMS) are offering states an unprecedented level of federal funding for information technology (IT) that can help determine eligibility.

These developments create significant opportunities for human services programs, which help low-income households pay for food, child care, energy costs, and other basic needs. Although it focuses largely on health coverage, the ACA opens the door for policies and practices that can reduce human services programs' error rates, lower their administrative costs, and cut red tape for families. In addition, for programs with uncapped enrollment, streamlining eligibility determination could increase participation by eligible families. Such increases would primarily affect the Supplemental Nutrition Assistance Program (SNAP), which accomplishes goals related to the ACA by reducing food insecurity, thereby improving low-income households' health status.[2]

Medicaid and new health coverage subsidies in the exchange are likely to reach more low-income households than any need-based program in American history. While some individuals newly eligible for health insurance are currently participating in human services programs, this may be the first contact with public benefit systems for others. The ACA encourages states to connect these new eligibility determination systems for health coverage with other need-based programs. However, unless human services advocates and administrators get actively engaged, these connections may not be made.

Human services programs like SNAP, Temporary Assistance for Needy Families (TANF), the Low-Income Home Energy Assistance Program (LIHEAP), subsidized child care, and others now face important questions: How can they leverage the ACA's new infrastructure to simplify and modernize their own eligibility procedures and systems? And how can they contribute to the success of the ACA's coverage expansion, ensuring that newly enrolled parents obtain the mental and physical health care services needed to facilitate employment and promote children's healthy development?

To help human services advocates and administrators understand and take advantage of these opportunities while limiting the risks presented by health reform, this paper begins by describing the ACA's key provisions. It then analyzes how other need-based programs could

build on the ACA to implement 21st-century eligibility approaches with highly streamlined methods of enrollment and retention. An appendix provides flow charts that illustrate how both online and in-person applications could be processed. The ultimate goal is a holistic system that meets the needs of low-income households, minimizes gaps between "siloed" work support programs, and reduces public-sector administrative costs, household burdens, and erroneous eligibility determinations.

The ACA

An overview of subsidy eligibility

Comprehensive descriptions of the ACA are available elsewhere.[3] For purposes of this analysis, however, it is important to understand the ACA's basic structure. Beginning on January 1, 2014, the following provisions will go into effect:

- Medicaid will cover non-elderly adults and children with incomes up to 138 percent of the federal poverty level (FPL).[4] For adults, this represents an extraordinary expansion in coverage. Under current law, childless adults, no matter how poor, are typically ineligible for Medicaid, as are parents whose incomes exceed 64 percent of FPL in the median state.[5] By expanding eligibility to 138 percent of FPL for all adults, the ACA is projected to increase the number of non-elderly Americans enrolled in Medicaid from 43 million to 60 million.[6] From 2014 through 2016, the federal government will pay 100 percent of health care costs for newly eligible adults. That percentage will begin declining in 2017, reaching 90 percent in 2020 and later years.

- In households with incomes at or below 400 percent of FPL, consumers will qualify for fully refundable[7] federal income tax credits to pay insurance premiums if the consumers are (a) ineligible for public coverage through Medicaid, the Children's Health Insurance Program (CHIP), and Medicare; (b) citizens or lawfully present immigrants; and (c) not offered employer-sponsored insurance that meets the ACA's minimum requirements for affordability and comprehensiveness. Tax credits are advanced directly to health insurers during the year, when premiums are due.

- Tax credit recipients with incomes at or below 250 percent of FPL will also qualify for cost-sharing subsidies. These subsidies increase the generosity of covered benefits by lowering deductibles, co-payments, and other out-of-pocket health care payments.

- The new federal subsidies will apply to coverage offered through state-level health insurance exchanges. Many exchanges will be operated by states. However, the federal government will assume this role if a state chooses not to do so or if the U.S. Department of Health and Human Services (HHS) finds that the state is unable to meet applicable requirements. In some cases, a state and the federal government may partner in the operation of an exchange. Regardless of who runs them, exchanges will provide services that include certifying health insurers' compliance with federal requirements, providing "one-stop shopping" that helps consumers choose health plans, and determining eligibility for "insurance affordability programs"—that is, subsidies in the exchange, Medicaid, and CHIP.

- For all insurance affordability programs, common income definitions will be used, based on Modified Adjusted Gross Income (MAGI). A major departure from traditional public benefit methods, MAGI counts income based on federal income tax rules, combining Adjusted Gross Income with tax-exempt interest and foreign earnings. Households are defined in terms of taxpayers and their dependents, rather than budget units as commonly understood by public benefit programs.[8]

- The ACA requires most Americans and lawfully present immigrants to obtain health coverage or pay a financial penalty. Exempt from this requirement are people whose income is sufficiently low that they are not required to file federal income taxes, people for whom coverage would cost more than 8 percent of income, people who show that purchasing coverage would constitute a hardship (under rules not yet promulgated by the federal government), and certain others.

Infrastructure for determining eligibility

The ACA requires each state's insurance affordability programs to use a single, integrated "shared eligibility service" for eligibility determination, enrollment, and retention.[9] By filing one common form, a consumer will initiate the application process for all programs. The shared eligibility service will conduct data matches with multiple federal sources of information relevant to eligibility, including a federal data hub that compiles material from a number of federal databases, such as those maintained by the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS). Documentation from the consumer is required only if data matches are not reasonably consistent with attestations on the health coverage application.[10]

An application can be initiated with the exchange, with social services agencies that determine Medicaid eligibility, or with a CHIP program. The form can be filed in person, online, by mail, by fax, or by phone. However and with whatever office the application is filed, government agencies must work together behind the scenes to determine eligibility and route each applicant and family member to the right program.

To make this data-driven approach possible, the ACA structures eligibility for health coverage in terms that largely fit available information, including through the above-described use of MAGI. In many (but not all) cases, tax records,[11] quarterly earnings that employers report to state workforce agencies, and real-time pay records available from private entities such as the "Work Number"[12] will be sufficient to establish income eligibility. Citizenship can often be established via data matches with SSA. Satisfactory immigration status will be verified using the longstanding Systematic Alien Verification for Entitlements (SAVE), which confirms eligibility through data matches with DHS records.

For a limited time, federal funding streams will fund the lion's share of investment in eligibility-related IT needed to operate this new system. The federal government will pay 90 percent of the cost of Medicaid IT development through December 31, 2015, after which the federal share reverts to the standard 50 percent.[13] Also, the federal government will pay 100 percent of the cost of IT development needed for health insurance exchanges to determine eligibility. Such exchange grants are available until January 1, 2015. In states that pursue an integrated

program of IT development that incorporates Medicaid and the exchange, these two federal funding streams will share expenses.[14] The federal share of total IT investment costs will thus fall between 90 and 100 percent. In a noteworthy departure from ordinary cost allocation rules, human services programs that gain from this IT investment do not need to share in its cost, so long as all development benefits health programs.[15]

To qualify for enhanced federal funding, a state must meet federal requirements, including those in ACA Section 1561. This section directs HHS to "develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs." In the words of the statute, such standards and protocols must allow for all of the following:

- "Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation;"

- "Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility;" and

- "Capability for individuals to apply, recertify and manage their eligibility information online, including … at points of service, and other community-based locations."

HHS describes as follows the requirements that states must meet to obtain these new resources:[16]

- "We expect IT systems to support a first-class customer experience, as well as seamless coordination between the Medicaid and CHIP programs and the Exchanges and between the Exchanges and plans, employers, and navigators. We also expect these systems to generate robust data in support of program evaluation efforts and ongoing improvements in program delivery and outcomes."

- "For most people, this routing and enrollment in the Exchange, Medicaid or CHIP will happen in real time."

- "Customers should experience this process as representing the highest level of service, support, and ease of use, similar to that experienced by customers of leading service and retail companies and organizations doing business in the United States."

- "Most individuals will be evaluated for eligibility in the Exchange, Medicaid and CHIP using a coordinated set of rules; as a result, we expect common systems and high levels of integration to avoid duplication of costs, processes, data, and effort on the part of either the state or the beneficiary."

The HHS Office of the National Coordinator for Health Information Technology has developed guidelines and standards to implement ACA Section 1561.[17] Those measures depart in three significant ways from the basic approach to eligibility systems previously used by most public benefit programs.

First, **the standards include a common definition of core data elements that facilitates effective and efficient communication between different computer systems**. Based on the National Information Exchange Model (NIEM) developed by the Departments of Homeland Security and Justice, this common definition resolves issues like whether date of birth is recorded in one field or three separate fields, whether this data element is called "date of birth" or "birth date," and similar questions. Existing state agency records do not need to change to fit these definitions. However, states will need to develop "translation" routines that allow their eligibility systems to answer queries and to report information using this federally promulgated, common definition of core data elements.

Second, as indicated earlier**, the federal government will develop a data hub that compiles multiple federal sources of eligibility-related information.** A state can access this information by entering into one data sharing agreement and then conducting matches with just one place—the hub—rather than making separate agreements and conducting individual matches with each source agency that feeds data to the hub. The shared eligibility service for insurance affordability programs will also connect to information outside the federal hub, including state-specific and privately maintained data.

Third, **eligibility criteria will be housed in an external repository of "business rules" that tell the system how to process information to determine eligibility.** Written in two languages—computer code and English—such rules will be the functional equivalent of manuals that states now use to guide the decisions of social services agency staff. But instead of being addressed to caseworkers, the business rules will run the computers that, whenever possible, determine eligibility. Under this new approach, caseworker actions to mechanically apply rules to applicants' factual circumstances are intended to become the exception, rather than the rule. At the same time, because the eligibility rules will be in an external rules engine rather than embedded within the actual operation of eligibility systems, changing these rules will be much faster and less costly than in the past. Among other benefits of this approach, it should reduce the need for costly and inconvenient work-arounds that afflict the operation of the decades-old computer systems that are used by many human services programs.

HHS is taking several additional steps to further help state IT development. First, the federal government is creating model software that states can use, without cost. Second, HHS has given several states "Early Innovator" grants to develop IT for health insurance exchanges. A key component of such IT involves determining eligibility for assistance, including through Medicaid. These Early Innovator states are expected to develop plug-and-play software that other states can use, at no cost. In addition, the California HealthCare Foundation is working with states and a leading private vendor to design online enrollment systems that low-income consumers will find easy to use.[18] As with the Early Innovator grants, this philanthropic initiative seeks to develop off-the-shelf products that will be free to states.

How human services programs can benefit from and support ACA implementation

Connecting health coverage applicants with human services programs

Medicaid, CHIP, and subsidized coverage in the exchange are expected to reach more low-income Americans than any other benefit program in history. As explained earlier, Medicaid eligibility will extend to 138 percent of the federal poverty level for adults and children, and the combination of CHIP and subsidies in the exchange will reach uninsured children and adults up to 400 percent of FPL. This coverage expansion is likely to be the subject of considerable public education and outreach as well as media coverage. Further, the ACA's streamlined system for eligibility determination and enrollment, described earlier, should increase participation above prior levels. In addition, the ACA will require almost all citizens and lawfully present immigrants to obtain health insurance, including many with incomes below poverty. Experience in Massachusetts, the only state to apply such an individual coverage requirement, suggests that even those with incomes too low to be subject to the requirement will pay much more attention to health coverage and therefore be more likely to enroll than in the past, since they may not realize that they are exempt.[19]

Many who receive health coverage as a result of the ACA will also qualify for human services programs that address other basic needs. If ACA applications could streamline access to these other benefits, more eligible households would join uncapped human services programs, which typically fail to reach a significant fraction of households who qualify for help. For example, federal officials estimate that only about two-thirds of eligible individuals received SNAP benefits in 2008.[20] And in programs where total enrollment cannot increase because of caps on funding or caseloads, tapping into ACA eligibility systems could achieve other gains, including less paperwork for families, fewer eligibility errors, and lower administrative costs.

To achieve these goals, consumers who finish the health coverage application could be asked whether they would like their application information shared with other state agencies to see if they qualify for other assistance. When an applicant consents, data on the health coverage application as well as relevant verification and documentation gathered by the ACA eligibility service would be immediately conveyed to the non-health program. Under a similar policy today, the Department of Education and the Internal Revenue Service invite families to have their individual tax return data used to prepopulate application forms for financial assistance with college.[21]

The appendix to this report contains flow charts showing how this general strategy could be operationalized. For the approach to achieve its potential in connecting ACA applicants with human services programs, the following three features will be important to include:

1. **As soon as a consumer asks the health program to share information, the information is conveyed electronically to the human services program, which begins determining eligibility without asking the consumer to file a new application.**
   This approach is likely to result in higher participation levels than if applicants for health coverage are simply screened and referred to other programs for which they then must submit applications. Even if consumers are linked to online applications for other programs or if they

are sent application forms through the mail, many will not complete those forms. For example, in 2002 the Social Security Administration sent 16.4 million letters to low-income Medicare beneficiaries who were probably eligible, according to federal income data, for Medicare Savings Programs (MSP). The letters provided information about MSP, which pays some or all Medicare cost-sharing, depending on income. The letters also listed a phone number that could be called to enroll. Only 74,000 people—0.5 percent of letter recipients—signed up for MSP as a result.[22]

More recently, Iowa and New Jersey have required taxpayers to indicate on state income tax returns whether their children have insurance coverage. In 2009, when parents in these states said that their children were uninsured, they were mailed application forms for health coverage, along with information about how to enroll. In Iowa, roughly 1 percent of parents filed application forms and sought coverage.[23] New Jersey streamlined its already simple child health application, based on the availability of tax data, and mailed out approximately 172,000 simplified forms to parents who indicated that their children were uninsured; roughly 750 children enrolled—less than 0.5 percent of the children in these families.[24]

This pattern is not limited to low-income households. Considerable behavioral economics research shows that, if households must submit an application for benefits, participation drops substantially, including among middle-class workers. In one classic example, only 33 percent of new employees enroll in 401(k) retirement savings accounts if they must fill out a form to enroll. If they are automatically enrolled unless they complete an opt-out form, 90 percent participate.[25]

Put simply, if policymakers want a substantial increase in human services participation among people who apply for health coverage under the ACA, they need to ensure that, when applicants ask for their information to be shared with a human services program, the latter program automatically begins determining eligibility without waiting for the client to complete a human services application form.[26]

2. The application process begins by seeing whether a consumer qualifies for Medicaid based on client attestations and data matches.

Once the ACA's data-driven eligibility process is complete, the consumer would be asked to provide any additional essential information. Such information may be needed by the human services program. In addition, for the many low-income consumers who lack a comprehensive and recent data trail, additional information may be needed to qualify for Medicaid. In either case, the consumer, whether applying online, by phone, or in person, would not be asked to provide any information until the streamlined Medicaid eligibility determination process had run its course.

Under this approach, when the human services program sought additional information needed to qualify consumers for benefits, it would avoid asking any questions that were already answered by information furnished by the health program. Eliminating redundant questions in this way would simplify enrollment, thereby increasing participation rates and lowering administrative costs. Methods of accomplishing this goal include (a) pre-populating the human services application form with information received from the health program; and (b) dynamically structuring web-based or phone-based application systems to eliminate questions

from the human services application that were already answered by information from the health program.[27]

Some consumers may not be able to complete, at a single session, both the health enrollment process and any additional steps required by the human services program. To help these consumers, online and phone systems could incorporate a "My Application" feature through which partially completed applications are saved and finished later.

In some cases, including when applications are submitted by mail, the human services agency will need to follow up with the consumer proactively to complete the eligibility determination. To facilitate such follow-up, consumers could be asked how they would prefer to be contacted—telephone call, text message, e-mail, Facebook, letter, etc.[28]

The approach recommended here avoids a traditional, multi-program application that requires consumers to begin by providing all information that might be needed by any program. In the past, such lengthy applications have prevented some consumers from enrolling in any of the programs for which they qualified. To avoid that problem, many child health programs have encouraged families to complete health-only applications, and some SNAP programs have done likewise with SNAP-only forms. Of course, consumers who wish to begin by filling out a multi-program application form should be allowed to do so, but if that is the default option, many consumers will not complete the enrollment process.

Beginning with the ACA's streamlined enrollment process before asking consumers other questions has additional advantages, in the context of the ACA. It is consistent with the ACA's requirements for processing health coverage applications, since eligibility for Medicaid and subsidies in the exchange will be tested using expedited methods before any other questions are asked. Critically important, this approach would simplify necessary IT connections between health and other benefit programs. That is because the ACA eligibility service need not address any human services issues, other than to request consumer consent to data transfer and then to export data to non-health programs. With state health officials facing enormous challenges meeting the ACA's requirements for 2014 implementation, such a simplified approach to IT connections could greatly enhance the feasibility of developing an effective ACA–human services interface before the current federal funding opportunity ends.

3. **Human services eligibility rules are revised to fit findings from health coverage programs.** Rather than simply apply their existing eligibility rules to information received from health programs, policymakers could modify the rules of non-health programs so that eligibility can be based on that information. The following discussion uses SNAP as an example, but the same approach could apply to any human services program.

   Under this strategy, SNAP eligibility automatically extends to people whom health programs have found to have MAGI at or below SNAP's net income threshold of 100 percent of FPL. This avoids the need for many households to provide additional information before qualifying for SNAP, thereby streamlining enrollment and reducing administrative costs.

   Establishing *eligibility* is not enough for SNAP to be paid, however. The SNAP agency must also determine *benefit levels*. Under one possible approach, SNAP would (a) provide interim benefits based on Medicaid income findings, pending the SNAP agency's determination of

income using standard SNAP rules;[29] (b) ask clients only for additional information needed to establish SNAP benefit levels, thereby eliminating duplicative requests for information already provided by the health program; and (c) obtain this information using whatever communication method is preferred by the client, including telephone, text message, e-mail, or visits to the social services office.[30]

To be clear, many people who qualify for SNAP under standard rules will not have MAGI at or below 100 percent of FPL. For example, someone found to have MAGI of 120 percent of FPL, based on data-matches showing circumstances several months in the past, may have income below 100 of percent FPL at the time of application because household income fell since the period covered by data. Someone else may have MAGI above 100 percent of FPL but net income, as defined by SNAP, below 100 percent of FPL, because of SNAP's income disregards and household definitions.

Accordingly, *the approach explored here would not disqualify consumers for SNAP based on information received from health coverage programs*. Rather, if such information does not show SNAP eligibility, the consumer would be encouraged to submit a more traditional SNAP application that would be processed and determined using normal SNAP rules and procedures. Put simply, eligibility based on health coverage information would supplement rather than replace current eligibility categories for human services programs.

A similar approach is taken by numerous current methods of using one program's findings to automatically qualify consumers for another program, including the following examples:

- "Categorical eligibility," through which receipt of TANF, Supplemental Security Income (SSI), or General Assistance establishes SNAP eligibility;[31]

- "Express Lane Eligibility," through which children qualify for health coverage based on the findings of other need-based programs;

- "Adjunctive eligibility," through which pregnant women and young children who receive Medicaid, SNAP, TANF, or certain other programs automatically qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);

- "Direct Certification" of eligibility for the National School Lunch Program based on a family's participation in SNAP, TANF, or certain other programs; and

- Low-Income Subsidies for Medicare Part D prescription drug coverage, which automatically extend to beneficiaries who received Medicaid or SSI during the prior year.

Notwithstanding these precedents, the approach discussed here would represent a major departure from SNAP's usual eligibility rules. The SNAP statute may nevertheless permit such a policy as a pilot or demonstration project.[32] If the U.S. Department of Agriculture's Food and Nutrition Service decides against such pilots and demonstrations, Congress could modify SNAP eligibility rules in the forthcoming farm bill, slated for action by the end of 2012.

This same approach could be applied to other human services programs. In fact, it may be an "easier lift" for most such programs, which have federal statutes that are much less prescriptive

than SNAP's. With subsidized child care, TANF, LIHEAP, and other programs, states may have the flexibility, under current law, to adjust their eligibility criteria to fit the information received from ACA's enrollment infrastructure. Such an adjustment would qualify households as income-eligible for such a program if their income, as determined by health agencies, falls below the human services program's income eligibility limit—in most programs, somewhere below 138 percent of FPL, which marks Medicaid's eligibility threshold. Even in capped programs that cannot serve more than a certain number of people, automatically granting eligibility based on determinations already made by health coverage programs could reduce applicant burdens and lower public sector administrative costs.

The federal agencies responsible for these human services programs could help this process move forward by issuing guidance that explicitly authorizes policies and procedures like those described here. They could also help by providing sample data sharing agreements, software, and business rules that include safeguards for privacy and data security.

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Helping health programs efficiently enroll eligible consumers

Human services programs could make a major contribution to enrollment into health coverage by providing Medicaid and the exchange with data relevant to eligibility. SNAP is a particularly promising candidate for such an effort, for several reasons:[33]

- It reaches nearly 45 million poor and near-poor people,[34] more than any other need-based, non-health program administered by states. One study found that, in 2002, when nutrition assistance reached many fewer people than today, the program served 22 percent of poor, uninsured parents and 15 percent of uninsured parents with incomes between 100 and 200 percent of FPL.[35]

- With frequent redeterminations of eligibility and an intense focus on lowering error rates, SNAP typically has up-to-date, accurate information about household income.

- SNAP and Medicaid use common computer systems in many states, which cuts the cost of establishing necessary data linkages.

Human services programs could thus conduct data matches with Medicaid programs to identify people who receive SNAP or other benefits but not Medicaid. Such individuals could be the target of outreach to help them enroll in health coverage. More effective, however, would be using the eligibility records of human services programs to qualify low-income consumers for health coverage. Such data-driven eligibility could reduce states' administrative burden of processing the coming flood of Medicaid applications. Administrative costs would be particularly low and participation effects particularly great if CMS permits states to go beyond

simply examining human services data to see if it shows MAGI under 138 percent of FPL. Ideally, CMS will permit states to automatically qualify consumers for health coverage based on the income determinations of SNAP and other human services programs, notwithstanding differences between those programs' income rules and MAGI.[36]

To increase Medicaid coverage while lowering Medicaid administrative costs, this approach would require developing IT linkages between Medicaid and human services programs. This could have the ancillary benefit of helping the latter programs obtain enhanced federal funding for their own IT development, as explained in the following section.

Modernizing the information technology that human services programs use to determine eligibility

Both health and human services programs have long been hampered by outdated computer systems used to verify and establish eligibility. Obsolete computer systems can raise operational costs, reduce the accuracy of eligibility determination, and inhibit streamlining that could improve access to benefits. The ACA's new time-limited, highly enhanced federal funding for eligibility-related IT development promises great progress for Medicaid. But for human services programs, the ACA's IT implications are more uncertain. Such programs face both unprecedented opportunities and major risks. As indicated earlier, the federal agencies with jurisdiction over Medicaid, SNAP, TANF, and child care subsidies have announced that investments in eligibility systems that serve Medicaid and other programs can be funded entirely with Medicaid dollars that receive a 90 percent federal match. This policy waives the usual requirement of allocating the costs of systems development among all programs that benefit from such development. Instead, a human services program must pay for only the *additional* costs of connecting to multi-program systems that serve Medicaid. This represents an extraordinary opportunity to improve human services programs' eligibility systems.

On the other hand, in many states, Medicaid and human services programs like SNAP and TANF share common eligibility systems. If Medicaid moves to a new, 21st-century IT architecture while human services programs continue to use their current, outdated IT systems, such programs could be forced to shoulder a much larger share of the latter systems' operating costs. To avoid this result, human services programs may need to collaborate with Medicaid in shifting to modernized eligibility systems.

As indicated earlier, ACA Section 1561 addresses more than health programs. Its "interoperable and secure standards and protocols that facilitate enrollment of individuals" apply to "Federal and State health and *human services programs*" (emphasis added).

Federal guidance about the implementation of ACA thus encourages health programs to incorporate other human services programs in the development of modernized IT.[37] But it is not clear how strongly state health officials will respond to such encouragement. The ACA makes many demands on states, and opening up new eligibility systems to other benefit programs could fall off the priority list for overwhelmed and understaffed health agencies. Some such agencies have indicated that they are focusing on establishing "vertical integration" among multiple health programs—Medicaid, CHIP, and new federal subsidy programs in the exchange—that serve people at different income levels. These agencies will leave for another

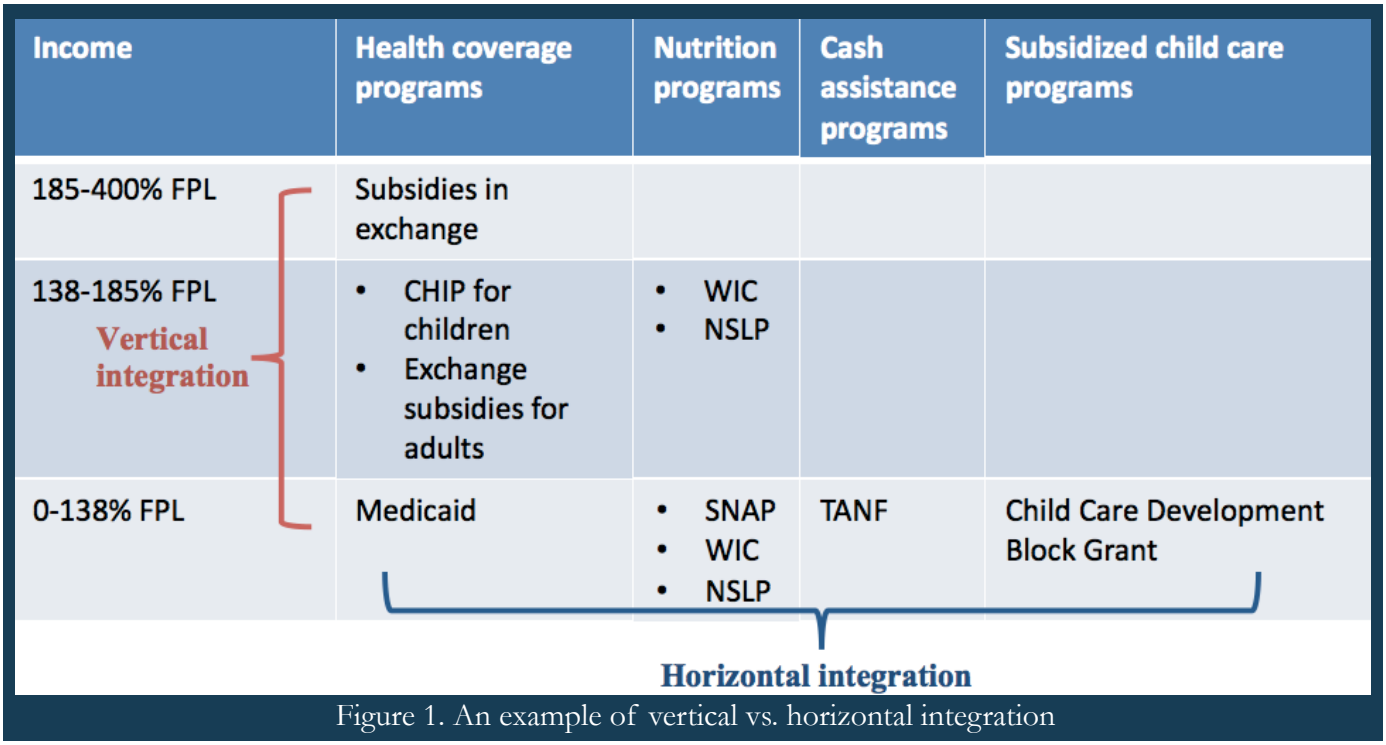


Figure 1. An example of vertical vs. horizontal integration

day "horizontal integration" that connects health and non-health programs offering multiple benefits to a common or overlapping group of low-income households (Figure 1).

Non-health programs could pay a heavy price if they cannot get horizontal integration placed on the short-term priority list for ACA implementation -- along with the potentially even more important priority of ensuring that human services eligibility systems are modernized along with Medicaid's. It is likely to be less costly and more effective to think about such integration as new computer systems are being structured, rather than trying to change such systems after they have been designed and built. At a minimum, it is essential for such systems to be designed with the possibility of adding functionality for additional programs down the road. One state administrator has described this as "leaving round holes for round pegs" to fit in, while a federal administrator has used the metaphor of building the foundations, electrical, and other systems to support a 10 story building, even if the initial stage is only 3 stories.

The ease of incorporating human services programs into Medicaid's IT development depends on the circumstances of each program. In many states, Medicaid and other programs share a common eligibility system. In such cases, the other programs could easily benefit from Medicaid's system improvements, particularly if they join efforts to plan the new eligibility infrastructure.

For human services programs that do not share a common eligibility system with Medicaid, enhanced federal funding for health IT systems might support the development of data connections with the ACA's eligibility system, including translation protocols between non-health program files and NIEM's common data elements. If human services programs pursue the above-described strategies for using their data to qualify eligible residents for health coverage, IT investments needed for such strategies to succeed might qualify for enhanced funding, since they would directly benefit Medicaid.

A request for this funding should presumably be included in a state Medicaid program's Advance Planning Document (APD), which CMS must approve before a state can receive enhanced federal funding. For this to happen, human services programs need to engage state health officials in the near term, while APDs are being developed.

Ensuring that social services offices remain viable avenues for seeking health coverage and other work supports

As suggested earlier, significant gains could result from the ACA's new, streamlined methods for online and telephonic enrollment. At the same time, access to coverage would suffer if these new pathways *displace* rather than *supplement* existing channels through which low-income households seek assistance. While many consumers prefer to submit applications online or by phone, others prefer in-person sessions with the staff of government agencies. According to recent research, many consumers in the latter group value the availability of help from well-informed staff. They also appreciate the chance to ask questions, to apply for multiple programs, to hand in paperwork, and to know that they have successfully completed an application. Particularly among Latino applicants, some also perceive an in-person process as more "official."[38] Put simply, the creation of effective application procedures that are online and telephonic does not diminish the need for first-class consumer experiences when low-income households seek health coverage and other work supports through personal visits to social services offices.

Tens of millions of low-income households currently use social services offices to obtain Medicaid and other need-based assistance. If Medicaid is removed from such offices' daily work, a channel of access to health coverage needed by many low-income consumers will close. Families who, today, provide their information once to a social services agency, which uses that information to determine eligibility for multiple benefits, would need to provide the same information redundantly to health and human services programs, likely impairing enrollment.

By contrast, both consumers and state agencies could benefit if social services offices incorporate the ACA's data-matching mechanisms into their regular operations, using procedures like those shown in the appendix to this report. As a family seeks multiple benefits from a social worker, access to ACA data-matching could let the worker obtain, potentially in real time, reliable information that could help determine whether the family qualifies for human services programs, in addition to health coverage. Taking an integrated rather than a siloed approach could thus help both health and human services programs achieve meaningful gains in efficiency, safeguarding program integrity, and providing access to benefits.

Using Medicaid to help accomplish core goals of human services programs

As of 2009, an estimated 43.3 percent of poor parents were uninsured.[39] The ACA will provide health coverage to many if not most of these parents, as the number of parents covered through Medicaid rises from 6.3 to 9.4 million.[40]

This expansion in parental coverage provides an opportunity for human services programs to accomplish some of their key missions more effectively. In particular, when low-income parents receive coverage and necessary treatment of depression and other health problems, two results typically occur:

- They are more likely to be effective parents, which increases the odds of their children's healthy development and may reduce the incidence of abuse and neglect;[41] and

- They are more likely to find and keep employment.[42]

To realize this potential, human services programs need to develop effective working relationships with Medicaid programs to facilitate enrollment into coverage by uninsured parents, including those with mental and emotional problems. Even with streamlined and simplified systems, many of these parents may need extra help signing up for Medicaid.

Enrollment alone does not ensure receipt of necessary care, of course. It will thus be important for human services programs and advocates to work with their Medicaid colleagues to ensure adequate amount, duration, and scope of covered benefits; reimbursement levels that recruit enough providers to furnish good access to care; support for innovative care delivery mechanisms that promote care coordination and access to services in primary care settings; and case management that tracks utilization and facilitates the receipt of necessary care.[43] Not only could such steps improve families' ability to function, states should also analyze whether new federal Medicaid dollars could substitute for some current social services spending, freeing up resources that could be used to provide low-income families with more effective assistance.

Conclusion

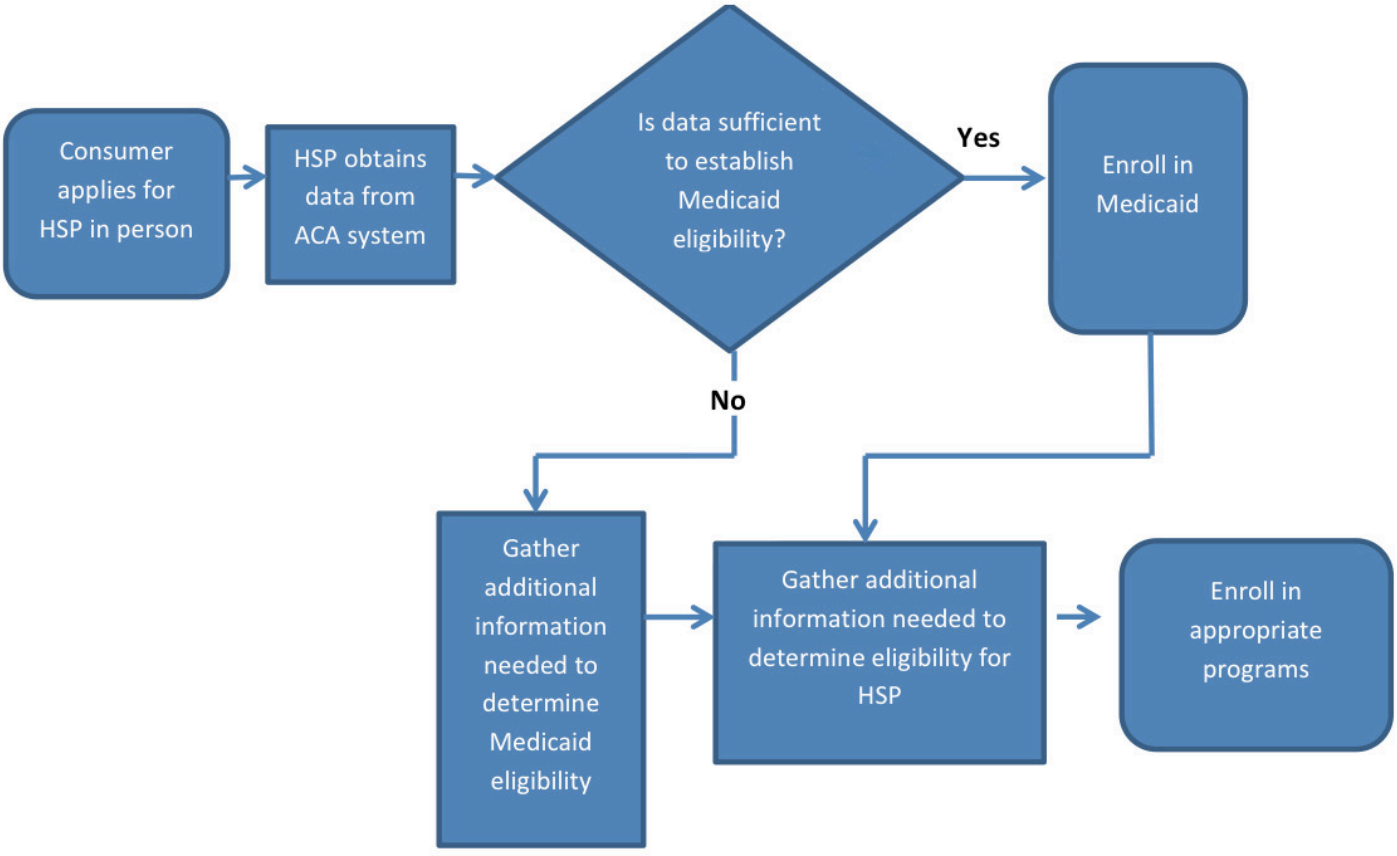
The ACA is breaking new ground in the administration of need-based assistance. Human services programs can benefit from this progress by linking to the legislation's new eligibility systems. Such programs may also be able to access enhanced federal funding that is available through 2015 to develop information technology needed for data-driven eligibility determination. These steps could increase household access to necessary work supports, cut administrative costs for state agencies, and prevent erroneous eligibility determinations.

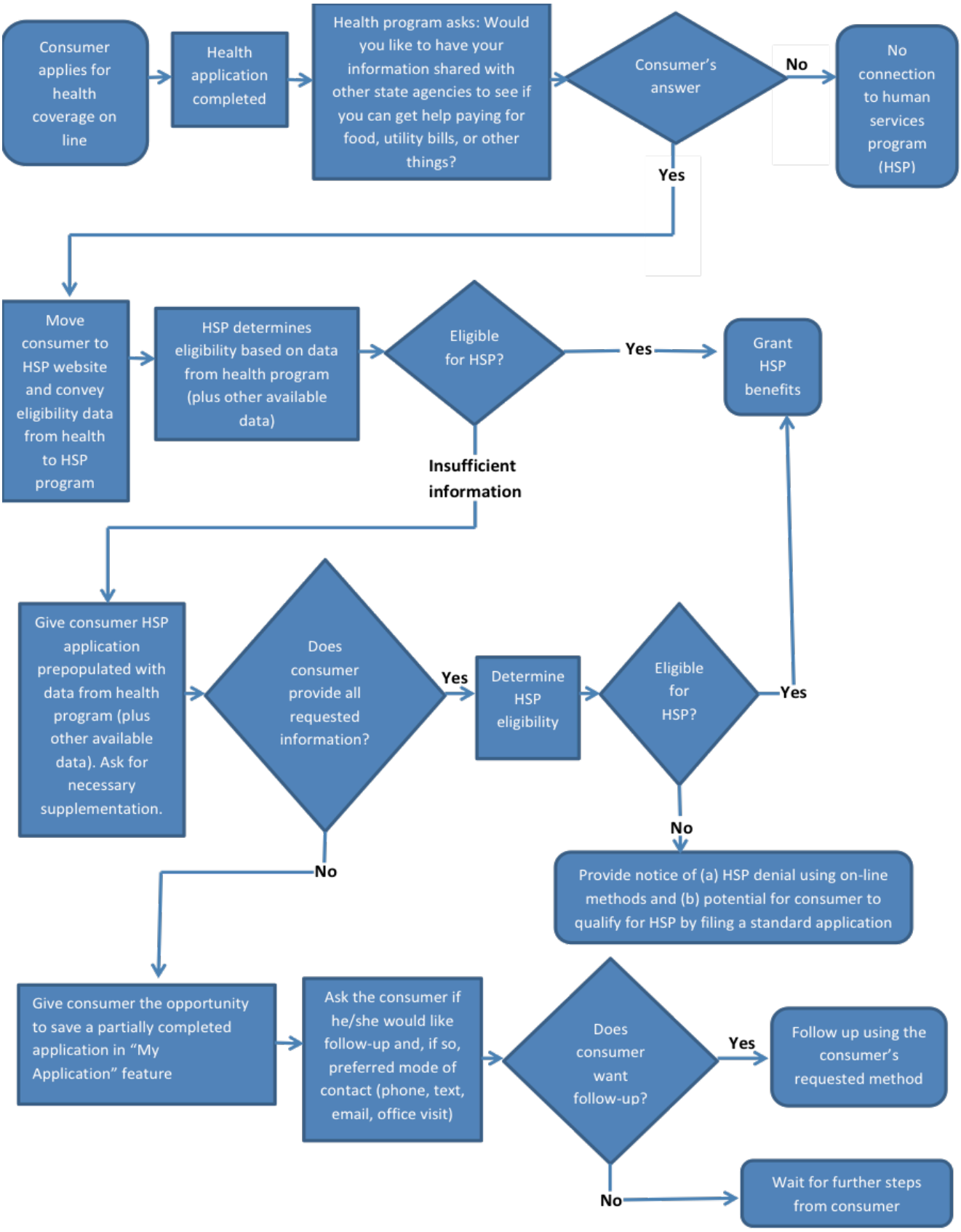
To achieve those gains, action is needed at both the state and federal levels. State human services programs need to engage with their health-sector colleagues sooner rather than later to ensure that state-level ACA implementation allows efficient and effective interface with non-health programs. And federal officials responsible for human services programs need to provide clear guidance to states about permitted options and viable models for connecting to the ACA's eligibility determination systems. With strong federal and state engagement, the country's public benefit programs can move towards a holistic and integrated system that uses 21st-century strategies for simultaneously promoting efficiency, accuracy, and needy households' receipt of promised benefits.

Appendix: Flow charts illustrating various approaches for integrated enrollment into health and human services programs

The following flow charts show several examples of how enrollment and eligibility determination procedures could be structured for health and human services programs. They show what might happen when—

- Someone applies for human services programs (HSP) at a social services office.
- Someone applies for health coverage online.




Consumer applies for health coverage on line
Health application completed
Health program asks: Would you like to have your information shared with other state agencies to see if you can get help paying for food, utility bills, or other things?
Consumer's answer
No
No connection to human services program (HSP)
Yes
Move consumer to HSP website and convey eligibility data from health to HSP program
HSP determines eligibility based on data from health program (plus other available data)
Eligible for HSP?
Yes
Grant HSP benefits
Insufficient information
Give consumer HSP application prepopulated with data from health program (plus other available data). Ask for necessary supplementation.
Does consumer provide all requested information?
Yes
Determine HSP eligibility
Eligible for HSP?
Yes
No
Provide notice of (a) HSP denial using on-line methods and (b) potential for consumer to qualify for HSP by filing a standard application
No
Give consumer the opportunity to save a partially completed application in "My Application" feature
Ask the consumer if he/she would like follow-up and, if so, preferred mode of contact (phone, text, email, office visit)
Does consumer want follow-up?
Yes
Follow up using the consumer's requested method
No
Wait for further steps from consumer

About the Author and Acknowledgments

Stan Dorn

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The Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.

Coalition for Access and Opportunity

The mission of the Coalition for Access and Opportunity is to share and publicize best practices, identify federal opportunities and promote policy reforms that will strengthen the safety net by removing barriers to participation. Our goals are to improve individual and family financial security, to advance health and well-being, to protect against material hardship and to promote opportunity and pathways to the middle class. The Coalition for Access and Opportunity is a collaboration of advocates, researchers, and practitioners working to improve access to and better coordination of the range of federal income and work supports.

Center for Law and Social Policy

CLASP seeks to improve the lives of low-income people. Through careful research and analysis and effective advocacy, CLASP develops and promotes new ideas, mobilizes others, and directly assists governments and advocates to put in place successful strategies that deliver results that matter to people across America. CLASP is nonpartisan and situated at the intersection of local practice, national research, and state and federal policy, and striving to translate each world to each other.

First Focus

First Focus is a bipartisan advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. First Focus takes a unique approach to children's advocacy, engaging both traditional and non-traditional partners in a broad range of efforts to increase federal investments in programs that address the needs of our nation's children. In all of its work, First Focus seeks to raise awareness regarding public policies impacting children and families and to ensure that related programs have the resources necessary to help children grow up in a healthy and nurturing environment.

Single Stop USA

Single Stop USA is a national nonprofit organization that seeks to alleviate poverty by helping families access all of the supports for which they are eligible at once, and as simply as possible. By partnering with community colleges and integrating its successful economic empowerment model with student service centers and financial aid offices, Single Stop seeks to harness two of the country's most effective anti-poverty tools—coordinated access to America's safety net and a postsecondary education. The aim is to increase the financial security of vulnerable students so they can complete degrees and ultimately to ensure that communities have access to the qualified workforce they need to meet growing labor demands.

Endnotes

1. For the text of the Patient Protection and Affordable Care Act (Public Law 111–148), including the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (''HCERA''; Public Law 111–152), see Office of the Legislative Counsel, Compilation of Patient Protection and Affordable Care Act, Print 111–1, http://docs.house.gov/energycommerce/ppacacon.pdf (accessed October 23, 2011).

2. See, e.g., Sharon I. Kirkpatrick, Lynn McIntyre, Melissa L. Potestio, "Child Hunger and Long-term Adverse Consequences for Health," Archives Of Pediatrics & Adolescent Medicine 164 (August 2010): 754–62; Craig Gundersen and Brent Kreider, "Bounding the Effects of Food Insecurity on Children's Health Outcomes," Journal of Health Economics 28 (September 2009): 971–83; A.F. Sullivan, S. Clark, D.J. Pallin, and C.A. Camargo, Jr., "Food Security, Health, and Medication Expenditures of Emergency Department Patients," Journal of Emergency Medicine 38 (May 2010):524–28; John T. Cook, Deborah A. Frank, Carol Berkowitz, Maureen M. Black, Patrick H. Casey, Diana B. Cutts, Alan F. Meyers, Nieves Zaldivar, Anne Skalicky, Suzette Levenson, Tim Heeren, and Mark Nord, "Food Insecurity Is Associated with Adverse Health Outcomes among Human Infants and Toddlers," Journal of Nutrition 134 (June 2004): 1432–38. For research about the effect of SNAP receipt on food insecurity, see Caroline Ratcliffe and Signe-Mary Mckernan, How Much Does SNAP Reduce Food Insecurity? Prepared by the Urban Institute for U.S. Department of Agriculture's Economic Research Service, Food Assistance and Nutrition Research Program, March 2010, http://www.urban.org/uploadedpdf/412065_reduce_food_insecurity.pdf (accessed October 16, 2011).

3. See, e.g., Kaiser Family Foundation, Summary of New Health Reform Law, April 15, 2011, http://www.kff.org/healthreform/upload/8061.pdf (accessed September 13, 2011); National Association of Insurance Commissioners & The Center for Insurance Policy and Research, Special Section: Patient Protection and Affordable Care Act & State Insurance Regulation, http://www.naic.org/index_health_reform_section.htm (accessed June 17, 2010); National Governors Association, Health Reform Implementation Resource Center, http://www.nga.org/portal/site/nga/menuitem.751b186f65e10b568a278110501010a0/?vgnextoid=7f8844ce25208210VgnVCM1000005e00100aRCRD&vgnextchannel=92ebc7df618a2010VgnVCM1000001a01010aRCRD (accessed June 17, 2010).

4. The nominal income threshold is 133 percent of FPL. However, 5 FPL percentage points are subtracted from MAGI in calculating Medicaid eligibility, so the actual income eligibility standard is 138 percent of FPL.

5. That figure is for working parents. For non-working parents, the median state terminates Medicaid eligibility at 37 percent of FPL. Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010–2011, Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured, 2011.

6. Matthew Buettgens, Bowen Garrett, and John Holahan, America Under the Affordable Care Act, prepared by the Urban Institute for the Robert Wood Johnson Foundation, December 2010.

7. Refundable credits are received by eligible taxpayers, regardless of their other tax liability. Accordingly, if such credits exceed tax liability, taxpayers receive the balance. The Earned Income Tax Credit (EITC) is perhaps the best-known example of a refundable tax credit.

8. For an exploration of the differences between MAGI and more traditional income methodologies for public benefit programs, see January Angeles, Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014, prepared by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, July 2011, http://www.kff.org/healthreform/upload/8194.pdf (accessed October 16, 2011).

9. CMS, "Medicaid Programs: Eligibility Changes under the Affordable Care Act of 2010," Federal Register Volume 76, Number 159 (Wednesday, August 17, 2011), Pages 51148-51199, http://www.regulations.gov/#!documentDetail;D=CMS-2011-0139-0002 (accessed October 16, 2011).

10. See proposed 42 CFR 435.952(c) in CMS, "Medicaid Programs: Eligibility Changes under the Affordable Care Act of 2010," op cit.

11. Such records are not limited to people who file tax returns. Income information is reported to the Internal Revenue Service, via W-2 wage records and 1099 forms, for non-filers and filers alike.

12. Equifax, the country's oldest and one of its three largest credit bureaus, is now a major source of income information to public benefit programs. Operating through its subsidiary TALX, Equifax offers a service known as "The Work Number" that provides earnings information about an estimated 38 percent of the workforce. TALX, Employer Verification, 2011, http://www.talx.com/Solutions/Compliance/Verifications/TWNEmployerBrochure.pdf (accessed May 9, 2011). TALX furnishes outsourced payroll and other targeted human resources services to numerous employers, including roughly three-fourths of the Fortune 500. One of these services is providing public agencies, lenders, and others with verification of employment and earnings, eliminating the need for TALX clients to provide such verifications themselves. TALX obtains earnings information when employees are paid, making that information available to contracting public agencies much more rapidly than is possible for publicly operated wage databases. TALX, Clients, http://www.talx.com/Aboutus/clients.asp (accessed May 9, 2011).

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14. Office of Management and Budget, OMB Circular A-87 Revised, http://www.whitehouse.gov/omb/circulars_a087_2004 (accessed October 16, 2011).

15. CMS, HHS Administration for Children and Families, and FNS, Tri-Agency Letter on Cost Allocation of Information Technology Systems,

August 10, 2011, https://www.cms.gov/smdl/downloads/tri-agency.pdf (accessed October 16, 2011).

16. CMS, Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0, May 2011, http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf (accessed October 16, 2011).

17. Office of the National Coordinator for Health Information Technology, Electronic Eligibility and Enrollment (updated January 10, 2011), http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161 (accessed September 11, 2011).

18. Terri Shaw, First Class User Experience Design for Affordable Care Act Implementation, presentation to the California Health Benefit Exchange Board Meeting, May 24, 2011, http://www.google.com/url?sa=t&source=web&cd=2&ved=0CBwQFjAB&url=http%3A%2F%2Fwww.statereforum.org%2Fsystem%2Ffiles%2Ffirst_class_user_experience_-_5-24_meeting.pptx&ei=R99nTsPJC8rk0QG51PX6Cw&usg=AFQjCNHPIEDyaqxqrQJEwwjHOouv6VTwFw (accessed October 16, 2011).

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20. Christine Kissmer, Reaching Those in Need: State Supplemental Nutrition Assistance Program Participation Rates in 2008—Summary, USDA, FNS, Office of Research and Analysis, December 2010, http://www.fns.usda.gov/ora/menu/Published/snap/FILES/Participation/Reaching2008Summary.pdf (accessed October 16, 2011).

21. Internal Revenue Service, Free Application for Federal Student Aid (FAFSA), June 14, 2010, http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_12059_912224_0_0_18/6-Rushin_IRS-FASFA-06142010.pdf (accessed October 16, 2011).

22. Government Accountability Office, Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries, GAO-04-363, March 2004. In the case of MSPs, sending notices increased the volume of phone calls, but few consumers managed to complete the enrollment process.

23. Brenda Freshour Johnston, Reaching Uninsured Children: Iowa's Income Tax Return and CHIP Project, prepared by the Iowa Department of Human Services for the State Health Access Reform Evaluation project of the Robert Wood Johnson Foundation, with the State Health Access Data Assistance Center serving as national program office, August 2010.

24. John Guhl and Eliot Fishman, New Jersey Family Care: Express Lane Eligibility, State Coverage Initiatives Program National Conference, July 2009.

25. David Laibson, "Impatience and Savings," National Bureau of Economic Research Reporter, Fall 2005: 6–8.

26. Such an approach could be even more effective if states contract with community-based organizations to conduct outreach and help low-income households complete the application and enrollment process.

27. With a dynamically structured form, a consumer's answers to particular questions can influence whether and, if so, how certain other questions are asked later in the form. Questions can also change based on information received from third-party sources.

28. In contacting consumers, agencies would need to safeguard privacy and data security. For example, Facebook or text messages could ask consumers to contact a social services agency at a certain phone number, without providing information about client circumstances; and email communications could be encrypted.

29. Such an interim award of benefits could continue until the agency recalculates household income and benefit levels, based on standard SNAP rules. This could take place either at the next regularly scheduled redetermination or earlier, if desired by the client.

30. A closely related approach would borrow more extensively from concepts already used by SNAP. This approach would grant categorical SNAP eligibility to clients found to have MAGI at or below a threshold level (such as 100 percent of FPL)—in effect, adding Medicaid to the current list of programs capable of establishing categorical eligibility for SNAP. Further, based generally on the current model of "Combined Application Projects," or CAP, which extend SNAP categorical eligibility to SSI recipients, standardized benefit amounts could be paid until the client's eligibility is redetermined using normal SNAP methodologies. Standardized benefits could be based on the amounts that, under the status quo, are typically paid to SNAP recipients with MAGI at comparable levels. Research would be needed to establish such standardized benefit levels. For more information about CAP, see FNS, Combined Application Projects: Guidance for States Developing Projects, March 2005, http://www.fns.usda.gov/snap/government/promising-practices/CAPsDevelopmentGuidance.pdf (accessed October 16, 2011).

31. Similar categorical eligibility applies to LIHEAP.

32. Section 11(t) of the Food and Nutrition Act of 2008 (7 U.S.C. 2020(t)) authorizes FNS to spend $5 million a year on grants for "simple application and eligibility determination systems and improved access to benefits." Funded projects can involve "coordinating application and eligibility determination processes, including verification practices, under [SNAP] and other Federal, State, and local assistance programs;" or "establishing methods for applying for benefits and determining eligibility that more extensively use communications by telephone and electronic alternatives such as the Internet or otherwise improve the administrative infrastructure used in processing applications and determining eligibility." Also, Section 17 of the Food and Nutrition Act (7 USC 2026) authorizes waivers, demonstrations, pilot projects, and research grants "to help improve the administration and effectiveness of [SNAP] in delivering nutrition-related benefits;" "to test program changes that might increase the efficiency of [SNAP] and improve the delivery of [SNAP] benefits to eligible households;" to "allow greater conformity with the rules of other programs than would [otherwise] be allowed;" and "waive any requirement of [the SNAP statute] to the extent necessary for the project to be conducted." The approaches described here, while novel in the context of SNAP, appear to fall within this broad statutory authorization.

33. Child support enforcement agencies also represent a promising source of data to qualify consumers for both health and human services programs. At the same time, such agencies can benefit from data-sharing agreements with health and human services programs, the records of which can be used to help enforce child support obligations.

34. Sheila Zedlewski, Supplemental Nutrition Assistance Counters High Unemployment, Urban Institute, July 2011, http://www.urban.org/UploadedPDF/412365-supplemental-nutrition.pdf (accessed October 16, 2011).

35. Stan Dorn and Genevieve M. Kenney, Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers, prepared by the Economic and Social Research Institute and the Urban Institute for the Commonwealth Fund, June 2006.

36. Social Security Act §1902(e)(14)(D)(ii), added by ACA §2002(a), expressly allows this with Express Lane Eligibility for children, but ACA also authorizes CMS to reach this result for adults through 1115 waivers. According to new Social Security Act §1902(e)(14)(D)(i)(I), MAGI does not apply to "[i]ndividuals who are eligible for medical assistance under … a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance."

37. For example, CMS requires the following from states seeking enhanced Medicaid FMAP for IT development: "States should consult with and discuss how the proposed systems development path will support interoperability with health information exchanges, public health agencies, and human services programs to promote effective customer service and better clinical management and health services to beneficiaries." CMS, Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement (MITS-11-01-v1.0), Version 1.0, April 2011 (emphasis added).

38. Lake Research Partners, Enrolling in Health Coverage in California: Preliminary Insights from Consumers on Enrollment Methods for Public and Private Health Coverage, prepared for the California HealthCare Foundation and The California Endowment, August 16. 2011.

39. Urban Institute tabulations of the 2010 ASEC Supplement to the Current Population Survey. This estimate excludes people in the Armed Forces. Parents are individuals over age 18 who live with their own children under age 19. The estimate does not adjust for underreporting of Medicaid/CHIP coverage.

40. Buettgens, Garrett, and Holahan, op cit.

41. Olivia Golden and Karina Fortuny, Improving the Lives of Young Children: Meeting Parents' Health and Mental Health Needs through Medicaid and CHIP So Children Can Thrive, Urban Institute, March 2011, http://www.urban.org/UploadedPDF/412315-Meeting-Parents-Health.pdf (accessed October 16, 2011); Olivia Golden, Amelia Hawkins, and William Beardslee, Home Visiting and Maternal Depression: Seizing the Opportunities to Help Mothers and Young Children, Urban Institute, March 2011, http://www.urban.org/uploadedpdf/412316-Maternal-Depression.pdf (accessed October 16, 2011).

42. Pamela J. Loprest, Sheila R. Zedlewski, Simone G. Schaner, Mental Health, Work and Mental Health Service Use among Low-Income Mothers, Urban Institute, August 2007, http://www.urban.org/UploadedPDF/411522_low_income_mothers.pdf (accessed October 16, 2011).

43. For more discussion of these strategies, see Golden and Fortuny, op cit.