CHIPRA Express Lane Eligibility Evaluation

Case Study of Alabama’s Express Lane Eligibility

Final Report

January 13, 2014

Margaret Wilkinson
Brigette Courtot
Ian Hill
This page has been left blank for double-sided copying.
This page has been left blank for double-sided copying.
Contents

Executive Summary ........................................................................................................................................... 2
1. Introduction .................................................................................................................................................... 6
3. Planning and Design ..................................................................................................................................... 11
4. Implementation ............................................................................................................................................. 13
5. Outcomes .................................................................................................................................................... 19
6. Looking Ahead ............................................................................................................................................. 21
7. Lessons Learned .......................................................................................................................................... 23
8. Conclusion .................................................................................................................................................... 25
Works Cited ..................................................................................................................................................... 26
Executive Summary

In October 2009, the Alabama Medicaid Agency implemented an Express Lane Eligibility (ELE) partnership with the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) programs—both administered by the Department of Human Resources (DHR)—to facilitate the enrollment and renewal of children into Medicaid. Under Alabama’s ELE initiative, Medicaid uses income eligibility findings from SNAP and TANF to automatically renew coverage for children enrolled in Medicaid and women enrolled in Plan First, a Medicaid program that provides family planning services to low-income women of childbearing age. Though CHIPRA does not authorize the use of ELE for adults, Alabama received federal approval to use ELE for Plan First via an 1115 Medicaid waiver. In addition to the auto-renewal approach, the state also operates a manual ELE process, under which Medicaid eligibility workers in the state can use SNAP and TANF income eligibility information to process Medicaid eligibility for children and Plan First enrollees at renewal and/or the time of initial application. Table ES.1 summarizes key facts about Alabama’s ELE program.

Alabama has long been a committed leader in supporting children’s public coverage through progressive eligibility policies. Since the early 2000s, the Covering Kids and Families coalition—comprised of state officials, child and family advocates, providers, and other stakeholders—had been considering policies that would streamline Medicaid and CHIP enrollment for children, based on their receipt of other public benefits. The passage of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in 2009 paved the way for Alabama to adopt such a policy under CHIPRA’s ELE option, at a time when recession-related hiring freezes and caseload increases were overwhelming Medicaid’s already-lean eligibility department and state policymakers were especially receptive to policy changes that would increase efficiency and automation. Hence, Medicaid officials moved quickly to implement ELE in collaboration with its partner agency, DHR.

SNAP and TANF were natural choices as partner programs for Alabama ELE, because both have eligibility limits within the range of Medicaid income limits and Medicaid eligibility workers were already familiar with accessing DHR databases when processing Medicaid applications. Just as importantly, DHR staff had long-supported the concept of using information collected by other public benefit programs to qualify children for Medicaid, in order to increase administrative efficiency and improve the eligibility and enrollment experience for families.
Table ES.1. Key Facts About Alabama’s Express Lane Eligibility Program

<table>
<thead>
<tr>
<th>Policy simplification adopted?</th>
<th>Express Lane Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy adopted in Medicaid, CHIP, or both?</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Processes affected?</td>
<td>Enrollment and renewal</td>
</tr>
<tr>
<td>If ELE, what eligibility factors are addressed by ELE?</td>
<td>Income, state residence, identity, Social Security</td>
</tr>
</tbody>
</table>
| Implementation date? | Enrollment: April 2010  
Renewal: October 2009 |
| Partner agencies (if applicable)? | SNAP and TANF (Department of Human Resources) |
| Is the simplified process different from the perspective of the enrollee/applicant? | Enrollment: No, families must still complete and submit a Medicaid application.  
Renewal: Yes, families are not required to complete a renewal form |
| Faster time to coverage for applicants? | Enrollment: Yes, ELE applications take less than 6 days, while standard applications take less than 25 days. |
| Any time savings for the state? | Enrollment: Yes, eligibility workers are able to process ELE applications more quickly than standard applications  
Renewal: Yes, approximately 47% of all renewals are automatically renewed via ELE and require no further action from eligibility workers |
| Estimated cost to implement? | An estimated $6,300 on programming work to implement the initial manual processes (Phases 1 and 2), and $23,000 for programming required to implement automatic renewals (Phase 3) |
| Estimated ongoing net administrative costs or savings? | Roughly $68,000 per year for the manual enrollment and renewal processes, and an estimated $1.1 million per year for automatic renewals |

Note: Facts about time savings, implementation costs, and ongoing net administrative costs and savings are taken from Mathematica’s analysis.

A defining feature of Alabama ELE is its phased-in implementation approach, a deliberate design decision that stakeholders credit with encouraging buy-in from both eligibility staff and state legislators. Specifically,

- **Under Phase One** (implemented in October 2009) eligibility workers manually access SNAP and TANF income eligibility findings—maintained in separate DHR databases—and
use the information to redetermine eligibility for Medicaid once a family has completed a renewal form. As of November 2012, coverage had been renewed for a total of 220,000 enrollees using this ELE process.

- In April 2010, Alabama rolled out *Phase Two*, allowing eligibility workers to use SNAP and TANF income findings (accessed manually as in the first phase) to qualify children and Plan First applicants for Medicaid coverage once they complete an initial application. As of November 2012, a total of 109,645 individuals were enrolled in Medicaid under this process.

- *Phase Three*, an automated Medicaid renewal process based on SNAP and TANF eligibility findings, was launched in February 2013, after a more intensive development process that involved technology changes and memorandums of understanding between the agencies involved. As of May 2013, a total of 92,673 Medicaid enrollees have been automatically renewed under this process.

Alabama’s manual ELE processes (Phase One and Two) have resulted in administrative savings of $68,000 per year; while modest, these savings far exceed the $6,300 it cost to implement the processes. Though the third phase of ELE was costlier to implement (at an estimated $23,000) the projected administrative savings associated with the automatic renewal process are much more significant. State officials anticipate that on an annual basis, coverage will be automatically renewed for about half of Alabama Medicaid clients (roughly 265,000 ELE renewals per year), contributing to a total estimated administrative cost savings of $1.1 million per year.

By most accounts, Alabama’s ELE initiative has achieved its desired outcomes and stakeholders are very satisfied with ELE. They feel that it is working as designed by increasing administrative efficiency and reducing eligibility staff workload. Moreover, ELE streamlines the process of applying for and maintaining Medicaid coverage for families, particularly the automatic renewal process. Several key lessons can be drawn from Alabama’s experience implementing Express Lane Eligibility. These include:

- **Using a phased-in approach allows for critical buy-in from eligibility workers and other stakeholders and can help make ELE a success.** The earliest manual ELE processes (Phases One and Two) required virtually no upgrades or investments in IT, so they could be implemented quickly and with less effort than later phases. The approach also gave the state time to gradually “ease in” to increased automation, allowing agency staff to become more familiar with it over time.

- **A good existing relationship between state agencies and longstanding support from a coalition of stakeholders enables quick responses to new policy options.** Alabama’s Covering Kids and Families coalition provided a forum for talking through ELE planning
and design issues, allowing the state to move quickly to adopt ELE. Alabama Medicaid and DHR had a history of working together, which facilitated ELE implementation; furthermore, as a social service agency, DHR has a similar mission to Alabama Medicaid and saw the value in helping their clients obtain medical assistance. However, officials acknowledged that despite strong working relations among agency leaders, there were challenges getting eligibility worker buy-in that it was acceptable to use the information obtained through ELE.

- **Using ELE for children only may have limited effectiveness in states like Alabama, where the Medicaid case unit is the entire household and enrollment/renewal for any adults on the case must be processed in the traditional manner.** To address this limitation, Alabama pursued an ELE process for women in Plan First. Since many households with Medicaid-covered children also include a woman on Plan First, implementing ELE for both coverage programs allows the entire family’s case to be renewed automatically, creating greater administrative efficiency and an easier application and renewal process for families.

- **Automated ELE processes lead to greater administrative savings and increased efficiency.** Despite the recent implementation of automated renewals (Phase Three), Alabama officials have already witnessed considerable savings, since these renewals generally require no time from eligibility workers. These savings are particularly beneficial given Alabama’s lean staffing model, budget-related hiring freezes, and recession-related growth in caseloads.

- **A nuanced approach to training—tailored to the perspective and concerns of the target audience—is important for ELE’s success.** ELE is a complicated concept that must be thoroughly explained to both eligibility staff and outside stakeholders whose support is crucial. Training and educational efforts tailored to the needs and concerns of eligibility workers—tasked with carrying out ELE—are critical for gaining their support.

At the time of our visit, officials in Alabama plan to implement two more phases of ELE in the future. A fourth phase would establish a process for automatic enrollment into Medicaid for uninsured children who are applying for SNAP or TANF, and a fifth phase would add new partner programs to the existing ELE structure. Despite a strong commitment to ELE from state officials, the timeline for implementing additional ELE processes has been delayed, due both to policymakers’ concern with the fiscal implications of an auto-enrollment ELE process, and because state officials have been focused on implementing the Affordable Care Act, leaving little time to devote to ELE.
1. Introduction

The Children’s Health Insurance Program (CHIP), a landmark legislative initiative passed in 1997 to help close the health insurance coverage gap for low-income children, was reauthorized with bipartisan support in 2009. Although CHIP had helped to fuel a substantial increase in health insurance coverage among children, Congress remained concerned about the many children—estimated at 4.4 million in 2010—who are eligible for but not enrolled in coverage (Kenney, Lynch, et al. 2012). In the CHIP Reauthorization Act (CHIPRA) of 2009, Congress gave states new tools to address enrollment and retention shortfalls, along with new incentives to do so.

One of these new options is a policy called Express Lane Eligibility (ELE). With ELE, a state’s Medicaid and/or CHIP program can rely on another agency’s eligibility findings to qualify children for public health insurance coverage, even when programs use different methods to assess income or otherwise determine eligibility. ELE thus gives states another way to try to identify, enroll, and retain children who are eligible for Medicaid or CHIP but who remain uninsured. The concept of using data from existing government databases and other means-tested programs to expedite and simplify enrollment in CHIP and Medicaid has been promoted for more than a decade; before CHIPRA, however, federal law limited state reliance on information from other agencies by requiring such information to be cross-walked into the Medicaid and CHIP eligibility methodologies (Families USA 2010; The Children’s Partnership n.d.). To promote adoption of ELE, Congress made it one of eight simplifications states could implement to qualify for performance bonus payments. These were new funds available to states that implemented five of the eight named simplifications and that also increased Medicaid enrollment (CHIPRA Section 104).

Federal and state policymakers are keenly interested in understanding the full implications of ELE as a route to enrolling children, or keeping them enrolled, in public coverage. To that end, Congress mandated an evaluation of ELE in the CHIPRA legislation. In addition to reviewing states that implemented ELE, the evaluation provides an opportunity to study other methods of simplified or streamlined enrollment or renewal (termed non-ELE strategies) that states have pursued, and to assess the benefits and potential costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand and assess the value of ELE and related strategies.

This report summarizes findings from a case study of Alabama’s Express Lane Eligibility program. The Alabama Medicaid Agency uses findings from the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) program—both administered by the state Department of Human Resources (DHR)—to automatically
renew coverage for children enrolled in Medicaid and women enrolled in Plan First, a Medicaid program that provides family planning services to low-income women of childbearing age. Eligibility workers in the state can also use income findings from SNAP and TANF to determine Medicaid eligibility for children and Plan First women at initial enrollment.

To learn about Alabama’s ELE program, staff from the Urban Institute conducted a site visit in March 2013, interviewing 28 key informants over a two-day visit to the state. The research team also conducted two focus groups with nine parents whose children were renewed in Medicaid via ELE. Parents shared their experiences with ELE and traditional enrollment and renewal for Medicaid, as well as their experiences obtaining health care services for their children.

2. State Context: Why Pursue ELE?

Alabama has long been a committed leader in children’s health insurance coverage. It is a source of great pride among state officials that Alabama was the first state in the nation to have a State Children’s Health Insurance Program (SCHIP) plan amendment approved following the passage of the Balanced Budget Act of 1997 and the creation of SCHIP (now called CHIP). Their program was rolled out in two stages, beginning with a small Medicaid expansion in February of 1998 that extended coverage to 15-18 year olds in families with income up to 100 percent of the federal poverty level (FPL), followed by the creation of a separate program—ALL Kids—in October of 1998, which provided coverage to uninsured children under the age of 19 above Medicaid income levels up to 200 percent FPL. Since the creation of these programs, Alabama has made steady progress in reducing the number of children without health insurance through a combination of income eligibility expansions and enrollment and renewal simplifications.

Progress in insuring children has resulted in large part due to close cooperation between the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH), which administers ALL Kids. Despite being administered by separate agencies, the eligibility and enrollment processes for the two programs have been well coordinated. Alabama has had a joint Medicaid/CHIP application from the start, and early efforts to align the

Focus Group Box #1: Outreach

Parents heard about Medicaid and Plan First from a variety of sources including family, friends, and health care providers. They received mixed opinions of the program.

“One of my friends told me about it.”

“I asked the doctor.”

“They just told me that I can sign up for Medicaid and that it would help...pay for the services.”

“I heard that they give you bad doctors, and you can’t choose who you want to choose for your child’s doctors.”
programs’ policies resulted in both programs allowing 12-month continuous eligibility (regardless of fluctuations in family income); no asset test or face-to-face interview as part of the eligibility determination process; and self-declaration of income and use of the same income disregards. Such alignment has greatly facilitated the exchange of information across the programs, and the required “screen and enroll” process—whereby children must be screened for both Medicaid and CHIP—as well as the movement of children from one program to the other when family income or circumstances change (Benatar et al., 2012).

In more recent years, Alabama’s efforts to reach and enroll uninsured children were facilitated by significant expansions of eligibility—in 2009, the upper income limit for ALL Kids was raised to 300 percent of poverty. In addition, Alabama was one of eight states to receive a Maximizing Enrollment grant from the Robert Wood Johnson Foundation, which supported technical assistance and the assessment of persistent challenges, development of goals, and implementation of strategies to improve enrollment and renewal processes (Brown and Nathan, 2010). Consequently, the years leading up to ELE saw the roll-out of a fully functional online application for both initial enrollment and renewal that allows the use of electronic signatures, and citizenship verification through a data match with the Social Security Administration (SSA). Renewal forms (both paper and electronic) are pre-populated with families’ information already in the system, and thus families are only required to confirm the continued accuracy of the data, or update information where necessary. None of these advances met resistance from the state legislature, consistent with the long-standing bipartisan support children’s coverage has enjoyed over the years.

As detailed in Table 1, Alabama was already on track to receive a CHIPRA performance bonus—even before implementing ELE—because the state had previously adopted: 12-months continuous eligibility; joint application and renewal forms; administrative renewals; and had eliminated both the assets test and in-person interview. These enrollment simplification efforts, coupled with continued strong enrollment growth, resulted in Alabama receiving CHIPRA performance bonuses four years in a row (2009, 2010, 2011, and 2012), totaling more than $43 million (InsureKidsNow, 2012).1

Adjunct Eligibility. Many of these progressive policies were facilitated by the Covering Kids and Families (CKF) coalition, a collaborative opportunity for stakeholders—advocates, agency and eligibility staff from Medicaid, ADPH and the Department of Human Resources (DHR), and others—to discuss, develop, and work to implement new and more streamlined eligibility and

1 After receiving these bonuses for FY 2009-2011 totaling over $110 million, CMS discovered a potential error in the calculation of Medicaid enrollment numbers for 2009 and 2010. After a series of discussions between Alabama Medicaid and CMS, bonuses amounts awarded after 2010 have been withheld, and CMS and Medicaid are still in discussions regarding bonus monies.
enrollment processes. Indeed, members of the CKF coalition began working to adopt an ELE-like process, which they referred to as adjunct eligibility, almost nine years before CHIPRA’s 2009 enactment. According to key informants who were involved in these early discussions, the adjunct eligibility concept emerged in response to concerns about lean staffing levels at the Medicaid agency and eligibility workers’ ability to enroll clients in a timely manner, and was reinforced by a desire to increase administrative efficiency. Recognizing that the eligibility frameworks across different public programs were similar, members of the CKF coalition began to explore the feasibility of using eligibility findings from other public benefit programs to qualify children for Medicaid and CHIP.

Table 1. Key Facts about Alabama’s Medicaid Program

<table>
<thead>
<tr>
<th>Medicaid/CHIP Program Type and Name</th>
<th>Separate, ALL Kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper income limits for Medicaid/CHIP</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Infants</td>
<td>133%</td>
</tr>
<tr>
<td>1-5</td>
<td>133%</td>
</tr>
<tr>
<td>6-18</td>
<td>100%</td>
</tr>
<tr>
<td>12 months Continuous Eligibility?</td>
<td>Yes</td>
</tr>
<tr>
<td>Presumptive Eligibility for Children?</td>
<td>No</td>
</tr>
<tr>
<td>In-Person Interview Required?</td>
<td>No</td>
</tr>
<tr>
<td>Asset Test?</td>
<td>No</td>
</tr>
<tr>
<td>Joint Medicaid and CHIP Forms for Application and Renewal?</td>
<td>Yes</td>
</tr>
<tr>
<td>Premium Assistance Subsidies?</td>
<td>No</td>
</tr>
<tr>
<td>Adult Coverage</td>
<td>Parents of dependent children without jobs below 10% FPL and working parents with dependent children below 23% FPL are eligible for Medicaid.</td>
</tr>
<tr>
<td>Renewal Processes</td>
<td>A pre-populated form is mailed out 60 days prior to coverage ending. Families are required to sign and mail back the form, even if there are no changes. All families can also renew coverage online, but only ALL Kids renewals are pre-populated online.</td>
</tr>
</tbody>
</table>

Sources: Site Visit Interviews, Heberlein et al. 2013, Kaiser State Health Facts

Alabama Medicaid examined various programs and their compatibility with Medicaid and quickly identified the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) as potential partners for an adjunct eligibility process. In particular, both programs have eligibility limits within the range of those of Medicaid. Families with incomes up to 100 percent of FPL are eligible for SNAP; while those with incomes below 11 percent of FPL are eligible for TANF. Additionally, both SNAP and TANF are administered by DHR, whose leadership had been willing partners at the CKF coalition and were supportive of
working with other state agencies to increase efficiency and alleviate burden on their clients. As one DHR official stated, “we all work for the same employer and are in this together…to help each other.” Indeed, DHR was an experienced partner of auto-enrollment initiatives, as it regularly shares data with the Department of Education to help identify children for the Free and Reduced Lunch Program.

To test the compatibility of the programs, the state ran a pilot match with the SNAP database in 2002 and found that almost 70 percent of children with Medicaid were also part of an active SNAP case, confirming the potential value of adjunct eligibility. That same year, state officials began to develop a waiver application to seek approval from CMS for a process that would automatically grant Medicaid eligibility to children with active SNAP cases. Before implementing any new initiative, Alabama Medicaid often seeks support from key stakeholders such as the Physicians’ Taskforce, the Medical Care Advisory Committee, other key medical groups, and the Governor’s Departments of Finance and Policy, although legislative approval is not usually needed for policy or administrative changes. Several key groups throughout the state lent their support to adjunct eligibility, including the Physicians’ Task Force and the Medical Advisory Committee as well as the provider community. The Governors’ Department of Finance, however, raised a number of concerns. First, the Department was apprehensive of the budgetary impact of potentially adding thousands of children to the Medicaid rolls. As key informants also pointed out, when considering new initiatives, Alabama policymakers often focus on the potential for fraud and abuse of public benefits. Consequently, state officials had significant concerns about the quality of the eligibility findings and the potential consequences of an increased error rate that could result from granting automatic eligibility.

Given these concerns, Medicaid staff ultimately decided not to submit their waiver to CMS. However, discussions surrounding adjunct eligibility continued over the next several years (primarily through the CKF coalition) and resulted in the implementation of a new policy that allowed Medicaid eligibility workers to manually access the DHR database to verify self-reported income when making their own eligibility determination. Key informants reported that this simplification did not have a huge impact, as eligibility workers continued requesting documentation from clients even with the information available from DHR, to avoid quality control errors.

Express Lane Eligibility. According to key informants, the passage of CHIPRA in 2009 paved the way for state approval of what they had been calling “adjunct” eligibility. In particular, the fact that CHIPRA allows states to exclude ELE determinations from their standard Medicaid eligibility error rate calculation eased the fears of state officials that implementing adjunct
eligibility would increase the state’s error rate. The ability to pursue ELE as a state plan amendment (rather than through a more time-consuming CMS waiver process) was also welcome. Moreover, by 2009, there was an even more pronounced demand for efficiency and automation; like many state agencies, Alabama Medicaid had experienced hiring freezes during the Great Recession, overwhelming eligibility staff and making it difficult to keep up with increasing caseloads. Finally, Medicaid officials were interested in reducing the number of Medicaid cases closed for failure to renew. Some key informants estimated that as many as a quarter of all cases up for renewal closed each month because a client had not completed renewal paperwork. Thus, shortly after the passage of CHIPRA, officials began intensive work designing an ELE process.

3. Planning and Design

Alabama’s early interest in adjunct eligibility through the CKF coalition allowed the state to plan and design its ELE process quickly, because it had already selected programs that were compatible with Medicaid and garnered support from advocates, stakeholders, and other state agencies. In the early design phase, Medicaid officials—with input from ADPH, DHR, and the advocacy community—recognized that it was “more practical” to implement ELE in several different phases (Table 2). This approach—beginning with manual renewals—allowed each phase to build off the work and changes implemented in the previous phase.

Manual renewals for children were a logical place to begin the ELE initiative because they could be implemented immediately; there were no systems changes required since (as noted above) Medicaid eligibility workers already had access to the SNAP and TANF databases and had been using them to verify Medicaid applicants self-reported income. As such, the state had already developed a Memorandum of Understanding (MOU) to share data in this manner, avoiding the need for a new MOU to implement Phase One of ELE. In addition, manual ELE renewals would require no changes to the application and renewal forms, or to any other client materials. Finally, key informants suggested that eligibility workers felt more comfortable using information from other (non-Medicaid) databases at renewal because the client had already gone through the rigorous initial application process and had been granted eligibility by a trusted eligibility worker at Medicaid.

Medicaid officials also expected that a phased-in approach, building on manual renewals for children, would encourage buy-in from eligibility workers, who would be more likely to support

---

2 States who adopted ELE are permitted by CMS to exclude children who have been enrolled or renewed via ELE from their normal error rate calculations. However, at the time of our visit in March 2013, CMS had not yet released detailed guidelines regarding how CMS would calculate error rates, and state officials expressed frustration over the continued lack of guidance concerning the calculation of error permitted under ELE.
the initiative’s later phases (which introduce larger-scale changes to the eligibility process) after first experiencing its positive effects on reducing caseloads and increasing efficiency via the smaller-scale early phases. Officials also recognized the need for legislative buy-in and felt that a phased-in approach would avoid political controversy and negative legislative attention by reducing the initial impact of ELE on the budget and demonstrating successful collaboration across state agencies. The phased proposal, combined with CHIPRA’s promotion of ELE and a pronounced need for efficiency, allowed the Medicaid agency to easily obtain support for the initiative from both the Physicians’ Task Force and the Governor’s Department of Finance in early 2009.

Table 2: Alabama’s Original ELE Implementation Approach

<table>
<thead>
<tr>
<th>Initial Target Date</th>
<th>Date of Implementation</th>
<th>ELE Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009</td>
<td>October 2009</td>
<td>Phase One: State eligibility workers are allowed to renew eligibility for children in Medicaid based on findings from the SNAP or TANF programs.</td>
</tr>
<tr>
<td>April 2010</td>
<td>April 2010</td>
<td>Phase Two: State eligibility workers can use findings from the SNAP or TANF programs to process initial Medicaid applications for children and referrals from the CHIP agency.</td>
</tr>
<tr>
<td>Fall 2010</td>
<td>February 2013</td>
<td>Phase Three: Medicaid can use findings from SNAP and TANF to automatically renew children and Plan First women (May 2012).</td>
</tr>
<tr>
<td>October 2013 (^3)</td>
<td>June 2013</td>
<td>Phase Three (b): Medicaid can use an automated daily match to verify SNAP or TANF eligibility for Medicaid pending applications. Workers no longer have to verify SNAP or TANF eligibility for enrollment.</td>
</tr>
<tr>
<td>2011</td>
<td>TBD</td>
<td>Phase Four: Medicaid will use findings from SNAP and TANF to automatically enroll new children.</td>
</tr>
<tr>
<td>2011</td>
<td>TBD</td>
<td>Phase Five: Express Lane Eligibility will be expanded to other programs and agencies.</td>
</tr>
</tbody>
</table>

Sources: Families USA, “Express Lane Eligibility: Early State Experiences and Lessons for Health Reform.” January 2011; Case Study Interviews

CMS Approval Process. Shortly after obtaining required approvals from state authorities in early 2009, the state began working with officials at CMS to gain approval for the state plan amendment (SPA) required to implement ELE. Given the amount of background work that had gone into the development of a CMS waiver for adjunct eligibility, officials found the development of the SPA and the approval process for ELE straightforward and simple. However, key informants noted that some officials at CMS did not initially consider Phase One a

\(^3\) Phase 3B was added after the initial planning phase as an interim step to full automation.
“true” ELE process because it relied on a manual intervention process that the state had been characterizing as adjunct eligibility for several years prior to CHIPRA’s passage. After explaining their plan to further automate the process in subsequent phases, Alabama was able to obtain CMS approval in October 2009 for its renewal process and again in April 2010 to use ELE for initial enrollment.

Consideration of ELE for CHIP. Initially, members of the CKF coalition envisioned using ELE for both CHIP and Medicaid. CHIP administrators at ADPH researched various programs and identified the childcare assistance program (housed at DHR) and the Women, Infants and Children (or WIC, housed at ADPH) program as potential partners. However, they found that neither was a “logical partner”, as the child care assistance income limits were more in line with Medicaid thresholds than those of CHIP, and several barriers were identified by ADPH officials that would prevent CHIP from using the WIC data in a meaningful way. Specifically, officials noted that the WIC data was kept at an individual level, while CHIP data was maintained at the family level. Despite this setback, CHIP officials continue to support the implementation of ELE in the state, but to date, they have not implemented ELE for CHIP.

4. Implementation

Phase One. Upon receiving CMS’ approval in October 2009, Alabama officials were poised and ready to quickly implement ELE for children. Under Phase One, eligibility workers manually accessed SNAP and TANF income eligibility findings—maintained in separate DHR databases—and used the information to renew children’s coverage in Medicaid. If a child was found to have an active SNAP or TANF case, the eligibility worker added an ELE indicator to the file—“S” for SNAP, “T” for TANF, or “B” for both—that would allow the state to track ELE cases and make them easily identifiable in the future. Although a similar policy—allowing Medicaid staff to access the DHR database—had been in place for several years, key informants noted that the ELE Phase One process was distinct in one critical aspect. Specifically, in the past workers could access income information in the DHR database to verify self-reported income, but were still required to conduct their own income calculations to redetermine eligibility, using Medicaid methodology. The implementation of ELE allowed workers to rely completely on the information in the DHR database—including DHR’s methods for calculating income—to renew coverage, eliminating the extra step of making their own determination based on Medicaid’s methods. As one eligibility worker assessed, Phase One “did not lessen the caseloads of renewals, but it lessened the time spent on renewals.”

Families whose children were renewed via Phase One were unaware that the cases had been processed via ELE because the state did not outreach to clients regarding the changes,
clients were still required to complete the traditional renewal form, and self-declaration of income had been accepted for Medicaid-enrolled children and Plan First enrollees for several years. Shortly after implementing Phase One, Medicaid officials identified an unanticipated barrier for families, stemming from the way renewals are processed and the income verification requirements that remained in place for adults receiving Medicaid for Low-income Families (MLIF). Specifically, renewals in Alabama are processed at the family level—where all members of a family who receive Medicaid are renewed at the same time. At the time Phase One was implemented, individuals receiving MLIF in Alabama were still required to submit documentation of their income. Thus, even if a child could be renewed via ELE, a family might still be required to submit income verification if a parent received MLIF, removing any potential benefit to the family provided by ELE.

Phase Two. In April 2010 Alabama rolled out Phase Two, allowing eligibility workers to rely on information contained in the SNAP and TANF databases to qualify children for Medicaid after they had completed an initial application for eligibility. To maintain a tracking system that distinguished between the two ways that ELE could now be employed, an additional flag was added to ELE files—“R” for renewal and “I” for initial enrollment. Aside from this small change, there were no other changes required to implement the manual ELE enrollment process, as the Medicaid application already included an affirmation statement that gave the Medicaid agency permission to use data from other sources when making an eligibility determination. To further improve upon the process of Phase One, the state coupled Phase Two with the implementation of a new policy allowing for self-declaration of income for individuals receiving MLIF, easing the burden on adults applying for Medicaid at the same time as their children.

Although the implementation of these two policies reduced the burden on families applying for coverage,
key informants acknowledged that they did little to streamline processes for eligibility workers. While eligibility staff reported that Phase Two “made it easier to process applications” because they were no longer required to calculate income for children applying to Medicaid, they were still required to do so for adults receiving MLIF or Plan First. Because many families apply for Medicaid on one application, caseworkers still processed many applications—even those where the child could be enrolled via ELE—using the same steps required under traditional application routes. In addition, some key informants noted that Medicaid eligibility workers were uneasy about relying on SNAP and TANF records to qualify individuals for Medicaid. Despite the collaborative relationship between DHR and Medicaid leadership, the Medicaid eligibility workers distrusted the information contained in the DHR system and noted that it did not contain the specificity or type of information they required for the Medicaid eligibility system.

ELE for Adults Enrolled in Plan First. Early on state officials recognized that the full benefits of ELE could not be realized if eligibility workers were still required to use traditional methods to determine income eligibility for parents with MLIF or Plan First who were involved in the same family case at enrollment or renewal. Consequently, after implementing the first two ELE phases, Medicaid officials began working with ADPH (a partner in administering Plan First) to identify the feasibility of using ELE for Plan First enrollees, as many Medicaid-enrolled children have mothers who are enrolled in Plan First, making it common for a family application or case to include both. Additionally, because family planning services are recognized as very cost-effective, state officials noted that support for streamlining the eligibility determination and renewal processes for Plan First enrollment was easy to obtain—“keeping women enrolled is really a win-win for everybody.” Because ELE for adults was not authorized under CHIPRA—and only one other state (Massachusetts) was considering its use for adults at the time—Alabama consulted with CMS and ultimately included the proposal in their Section 1115 Plan First waiver renewal to CMS in 2011.

Despite CMS’ support for the idea, key informants noted that the federal approval process for the waiver was lengthy. After several months, however, CMS approved the use of ELE for Plan First women in April 2012, and the state quickly moved to integrate Plan First women into the existing ELE processes. Beginning in May, Medicaid eligibility staff began using information contained in the SNAP and TANF databases to determine initial eligibility for and renew Plan First coverage. Key informants cited this as a critical change, as it allows eligibility workers to process an entire family case via ELE, and has led to noticeable time savings for eligibility workers.

Phase Three. Alabama implemented Phase Three—an automated Medicaid renewal process based on SNAP and TANF eligibility findings—in February 2013, after a lengthy development process that involved considerable Information Technology (IT) changes and new MOUs. To
facilitate the new process, staff at DHR researched various ways to efficiently and effectively match and share data. Rather than running Medicaid data against both the SNAP and TANF systems separately, DHR ultimately chose to match the data against the Income and Eligibility Verification System (IEVS). Before this could occur, both the SNAP and TANF databases were synced to IEVS. Once all three systems were synced, DHR staff ran Medicaid test files against IEVS to ensure they were able to locate and match active recipients.

In addition to the IT changes, DHR and Medicaid were also required to develop a new MOU that would allow for more detailed and intensive data sharing between the two agencies. Informants described the MOU process as straightforward, citing their previous collaboration in the CKF coalition and earlier ELE phases. However, they noted that the bureaucratic process was still time-consuming, and at times challenging given the complexity of the process. Although not required by the MOU, leadership from the TANF team at DHR also chose to update that program’s client application to reflect the new process. Specifically, the affirmation statement was adjusted to give DHR explicit permission to share information with Medicaid if clients had applied for family assistance.

Medicaid staff initially intended to use ELE to automatically renew coverage for both children and Plan First women. Based on their experiences implementing the first two phases, they recognized that the benefits of automatic renewal to Plan First women with children were evident—since eligibility workers could process an entire family’s Medicaid case using ELE. However, the benefits of automated renewal via ELE to women enrolled in Plan First without children (which represented a much smaller group than those with children) were somewhat unclear, as a majority of such women were not enrolled in either SNAP or TANF. Moreover, DPH contracts with an outside vendor to administratively renew women without children, making it more complicated to implement an automatic renewal process for the population. Thus, officials decided to rely on automatic renewals only for women with children, but believed that they would also eventually transition Plan First-enrollees without children to the new automated process.

To facilitate the automatic renewal process for children and Plan First-enrollees with children, Medicaid sends a monthly data file to DHR containing the names of all clients up for renewal. The cases are automatically matched on the IEVS and an indicator—S for SNAP, T for TANF, or B for Both—is automatically added to the client’s file before being sent back to

---

4 The 1984 Deficit Reduction Act mandated that every state use an income eligibility and verification system to access income information from federal and state agencies—including the Internal Revenue Service, quarterly wage reports, and unemployment benefits—to reduce errors in determining eligibility for Food Stamps, Aid to Families with Dependent Children, and Medicaid.

5 Plan First-enrollees without children receive a pre-populated renewal form containing eligibility information available to the state. To renew coverage, women are required to return the form indicating any changes.
Medicaid. The Medicaid system then automatically renews any case with an ELE indicator and generates a list of clients who have been automatically renewed that is sent to local eligibility staff. Although the Medicaid eligibility system is automatically updated with this information, eligibility workers interviewed for this case study reported that they were still manually pulling paper case files to document that a case had been renewed through ELE. On the other hand, state officials were aware that some caseworkers had been taking this extra step, and reported that they were communicating to eligibility staff that such efforts were unnecessary. Some enrollees who do not qualify for automatic renewal continue to be processed through the manual ELE renewal process (Phase One), which remains in place despite the implementation of an automated renewal process.

Families renewed automatically through ELE receive a one-page letter informing them that their case has been renewed using data available from DHR. The letter also instructs families to call a toll-free number to report any changes and warns that they could be responsible for retroactive payments if they do not report changes that would affect their continued eligibility. Key informants believed that families receiving the letter recognized the DHR agency name and thus understood that the information used for their Medicaid renewal came from SNAP or TANF. However, several eligibility workers reported client confusion regarding the requirement to report changes, as many had been receiving calls from families just to confirm that there were no changes (which is unnecessary).

While implementation of Phase Three has been relatively smooth, some key informants made suggestions for how the explanatory letter could be

<table>
<thead>
<tr>
<th>Focus Group Box #3: ELE Compared to Traditional Renewal Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under both the traditional renewal process and Phase One of ELE, families are still required to complete a renewal form and return it to the state. Focus group participants were therefore unaware of whether their coverage was renewed using the manual process via ELE’s first phase.</td>
</tr>
<tr>
<td>“[The renewal form] is kind of like the application form, you just fill it out over again.”</td>
</tr>
<tr>
<td>“Your caseworker sends you a paper you have to fill out if anything is changed. Information is already on there, and you just sign it, or you can…make changes.”</td>
</tr>
<tr>
<td>Parents whose children had been renewed via Phase Three reported great satisfaction with the new automated process, specifically noting how much easier it was than previous years.</td>
</tr>
<tr>
<td>“It’s always been a piece of cake for me…but recently this year, when they sent the letter, it actually had the information. Just call and verify that the information is still the same.”</td>
</tr>
<tr>
<td>“I think they said they already verified [income]”</td>
</tr>
<tr>
<td>“It was better.”</td>
</tr>
<tr>
<td>“It’s getting easier.”</td>
</tr>
<tr>
<td>“I think it’s a good idea because you don’t have to worry about anything.”</td>
</tr>
</tbody>
</table>
improved so that it was easier for families to understand. Specific examples included clarifying that clients do not need to call the provided toll-free number unless they want to report changes in income or family circumstances, as well as clarifying that DHR refers to the SNAP and TANF programs. State officials indicated that they would be reviewing and making further improvements to the letter in the coming months.

**ELE-Related Trainings and Education.** Each phase of Alabama’s ELE implementation was preceded by efforts to educate eligibility workers on upcoming changes. State officials recognized that ELE’s success relied on whether the Medicaid agency was able to “change the culture of eligibility determination at the local level.” Eligibility workers receive notification of any new policy change, including ELE-related changes, through a notice sent by regular mail or over email. For bigger policy changes, the state also holds webinars and conference calls to fully explain the policy and allow for questions. From the outset, state officials were concerned about the possibility of resistance from eligibility staff, who take great responsibility for and pride in the accuracy of their determinations. They were also sensitive to caseworkers’ anxiety over the consequences of increasing automation for their role and job security. As a result of these concerns and in acknowledgment of the general complexity of ELE, Medicaid officials held three trainings with eligibility staff regarding ELE. Throughout these trainings, Medicaid officials made a point to emphasize the benefits of ELE for eligibility workers, including the increased efficiency and reduced caseloads.

Although the training and a phased-in approach to automation did help to garner the support of local level staff, key informants noted that there was still slight resistance and skepticism related to ELE, particularly after implementing Phase Three. Indeed, some Medicaid eligibility workers interviewed for this case study expressed serious concerns about the integrity of recertifications made under Phase Three. In particular, they questioned the different eligibility methodologies used by the programs, especially the way in which SNAP and TANF count households. As one eligibility worker observed, “The Medicaid eligibility methods are ingrained in caseworkers; using another program’s eligibility findings is a real conflict for us.” Others were cautious about the quality of the information contained in the DHR system, noting their perception that it lacked the level of detail typically collected during Medicaid enrollment or renewal.

Consequently, Alabama officials described a need to continuously educate Medicaid eligibility staff about ELE, and to monitor on an ongoing basis how ELE is being implemented “on the ground.” They found, for instance, that despite policies allowing self-declaration of income, a number of clients continue to submit pay stubs with their Medicaid application or renewal form; in such cases, some Medicaid eligibility workers continue to use the pay stubs to calculate income under Medicaid methodology, even when the applicant is eligible for ELE-
based enrollment or renewal. Accordingly, state officials have worked to communicate to Medicaid eligibility workers that ELE processes should take precedence over traditional eligibility determination methods, to maximize ELE-related gains in administrative efficiency and reduce caseworker burdens. A fully-automated ELE process circumvents this type of issue, since it does not rely on Medicaid caseworkers to actively choose ELE over a more traditional process. The choice of ELE is automatic, which state officials see as a major advantage because it “removes [caseworker] subjectivity” from the eligibility determination process. State officials are confident that Medicaid eligibility workers will become more accustomed to ELE and more appreciative of the administrative efficiencies it offers. As one key informant summarized, “the procedures have spoken for themselves; making things easier for workers.”

5. Outcomes

Key informants were near universal in their assessment that Alabama’s ELE initiative had achieved its desired outcomes. They felt ELE was working as designed by increasing administrative efficiency, reducing eligibility staff workload, and streamlining the application and renewal processes for families. Alabama’s ELE outcomes are described in more detail below.

**Enrollment and Renewals:** State officials estimate that, as of November 2012, a total of 220,000 enrollees had been renewed through the Phase One ELE process, whereby Medicaid eligibility workers manually accessed the SNAP and TANF databases and used those programs’ income findings to redetermine Medicaid coverage. A total of 109,645 individuals had been enrolled through Phase Two ELE, under which Medicaid eligibility workers used income information from SNAP

<table>
<thead>
<tr>
<th>Focus Group Box #4: Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Focus group participants were satisfied with their primary care providers, but reported problems accessing specialty dental care. When accessing care, some parents felt their children were treated differently than privately insured children.</em></td>
</tr>
<tr>
<td>“He’s very good... There are never too many people there, he always gets [my child] in and out.”</td>
</tr>
<tr>
<td>“I’ve been satisfied with it”</td>
</tr>
<tr>
<td>“My son’s first pediatrician, we had some trouble getting in. But the pediatrician we use now, no trouble.”</td>
</tr>
<tr>
<td>“I didn’t like their doctor... so I just changed [and] the one I have now, he’s like the best doctor ever.”</td>
</tr>
<tr>
<td>“You kind of sense the difference [in how] they treat you when you have Medicaid.”</td>
</tr>
<tr>
<td>“My oldest daughter had to have a root canal done, and they don’t take [Medicaid] here in Montgomery so I had to take her to Birmingham.”</td>
</tr>
</tbody>
</table>
and TANF to determine eligibility for Medicaid at the time of initial application. Under Alabama’s most recently-implemented Phase Three, a total of 92,673 Medicaid enrollees have been automatically renewed using SNAP and TANF income eligibility findings as of May 2013. Most key informants expressed satisfaction with this outcome; however, some noted that they initially expected the auto-renewal numbers to be higher before realizing that, due to the family-case renewal structure in Alabama Medicaid, only cases with children and Plan First enrollees are eligible for Phase Three.

Program Costs: Implementation of Alabama’s first and second phases of ELE cost a total of $6,300, which was spent on staff programming time to add the ELE indicator to the Medicaid eligibility system. Because Phase Three required more substantial programming to create processes for matching data between the IEVS, SNAP, and TANF systems, and for transferring data between Medicaid and DHR, implementation costs were higher, at $23,000. Key informants felt that ELE costs for all phases were reasonable, especially given the potential for administrative savings that would far exceed the initiative’s costs. A portion of Alabama’s ELE implementation costs—specifically those related to DHR’s portion of the Phase Three costs—were supported by a grant from a private foundation (under the Robert Wood Johnson Foundation’s Maximizing Enrollment initiative). DHR officials noted that these grant funds covered the agency’s Phase Three programming costs, estimated at $11,000, entirely. Remaining costs were covered through the Medicaid agency’s annual budget.

Administrative Efficiencies: Alabama’s manual ELE processes (Phase One and Two) have resulted in modest administrative savings. State officials estimate that implementation of these phases has reduced the amount of time an eligibility worker spends processing an ELE-eligible renewal or initial application by less than five minutes; overall, the cost savings to the state from these phases is estimated at $68,000 per year.

The administrative savings associated with the third phase of ELE, however, are much more significant. Since this ELE process involves complete automation of the renewal process, with virtually no involvement of Medicaid eligibility workers, a total of 35 minutes of staff time is saved per auto-renewal. State officials anticipate that on an annual basis, coverage will be automatically renewed for about half of Alabama Medicaid clients (roughly 265,000 ELE renewals per year), contributing to a total administrative cost savings of $1.1 million per year.

Client Perspective: With regard to ELE’s influence on Medicaid clients’ enrollment and renewal experience, key informants agreed that all phases of the initiative had resulted in positive outcomes for clients, though most highlighted the automatic renewal process (Phase Three) as the most significant change by far for Medicaid enrollees.
From the client’s perspective, the first two phases of ELE effectively reduce the likelihood that a new Medicaid applicant or enrollee up for renewal will be required to submit income documentation as part of their Medicaid eligibility determination or redetermination. But as a practical matter, relatively few Medicaid applicants and renewal candidates are currently required to submit such documentation even under the traditional eligibility processes, since Alabama has adopted policies allowing self-declaration of income and electronic verification through third-party databases like IEVS. In view of this, key informants noted that ELE Phase One and Two may have direct benefits for some applicants (particularly those who are self-employed, given that they are regularly required to submit income documentation), but that many others would not notice any difference between ELE and traditional eligibility processes. As one eligibility worker explained, “Parents aren’t even aware of Phase One or Two; they just know that their child is eligible.”

The ELE automated renewal process implemented under Phase Three, in contrast, is very different from traditional renewal. The latter is typically a three-month process, beginning with a prepopulated renewal form that is mailed to enrollees in advance of their redetermination date; it also requires enrollees to take action to retain their coverage by reviewing the form, filling in or updating information as necessary, and then returning it within the allowable timeframe. Under ELE, eligible enrollees are not required to take any action to retain their coverage—they are informed of their automatic renewal after the fact, via an explanatory letter. According to key informants, automated renewals make the redetermination process “family friendly,” simpler, and less duplicative, saving families the time and effort of completing renewal paperwork. This was confirmed through focus groups with parents who had experienced automatic renewal for their children’s Medicaid and their own Plan First coverage—all were very satisfied with the new process and noted how easy it was (see Focus Group Findings #3). Some key informants also emphasized the potential for Phase Three to reduce churning in and out of Medicaid (i.e., when a client fails to renew coverage but remains eligible, and then reapplies and reenrolls a short time later) and thus improve continuity of coverage and access to health care.

6. Looking Ahead

Additional ELE Phases. Despite a strong commitment to ELE from state officials, it is not clear yet when Alabama will implement the remaining two phases of its ELE program. Initially, Medicaid administrators hoped to quickly follow the implementation of automatic renewals with Phase Four, which they hoped would similarly automate initial enrollment for Medicaid using SNAP and TANF eligibility findings. However, the timeline for implementation has been delayed for several reasons. To begin, government officials are concerned with the fiscal
implications of adding SNAP and TANF applicants into Medicaid automatically, when those enrollees were not necessarily seeking health coverage. Moreover, Medicaid staff—who are building their own modernized, Affordable Care Act-compliant eligibility and enrollment system from the ground up—have been preoccupied with this major undertaking, leaving little time to devote to ELE.

In March 2013, key informants were still hopeful that Phase Four could be implemented before the Affordable Care Act-related open enrollment period began on October 1, 2013. However, at the time of our visit, several key decisions necessary for the implementation of Phase Four had not yet been made. Most importantly, Medicaid and DHR officials had not yet decided whether to obtain an applicant’s consent to enrollment (a necessary step for ELE-generated automatic enrollment, per CHIPRA rules) via an opt-in process (i.e., families would be required to check a box on the SNAP or TANF application to allow Medicaid to automatically enroll them into coverage) or an opt-out process (i.e., families would be required to call Medicaid after receiving notice of their eligibility to opt-out of coverage). While Medicaid officials expressed a preference for an opt-in process, which would reduce the amount of work on the Medicaid side by eliminating the need for Medicaid to track clients and reducing the amount of communication required between Medicaid and clients about their new health coverage, advocates and other stakeholders in the state are encouraging the use of an opt-out process that could potentially reach and enroll more families. In addition, Medicaid administrators were anticipating major IT changes required to facilitate an automatic enrollment process, but were unsure of the extent and cost of those changes. However, several key informants believed that an existing interface between Medicaid and DHR—currently being used for elderly and disabled clients—offers a promising start.

While key informants were generally very supportive of the first three phases of ELE, opinions about the fourth as-yet unimplemented phase were more mixed. Some indicated cautious support for an automatic enrollment process but emphasized the need for client education on how to use health coverage benefits (e.g., the importance of preventive care, choosing a usual source of care), noting that this was especially important in a situation where a new Medicaid enrollee had not actively pursued health coverage. Since the time of the site visit, state officials have implemented an interim step—referred to informally as “Phase 3b”—that automates a portion of the Medicaid application process. Under this phase, income information from SNAP and TANF databases is automatically entered into a Medicaid application that a family has already completed and submitted, eliminating the need for a Medicaid eligibility worker to verify income.6

6 At the time of writing, it is unclear whether (and when) the state will implement a fully automated enrollment process (Phase 4).
Further down the road, Medicaid officials hope to add new programs to the already existing ELE structure in a fifth phase. Advocates participating in the CKF coalition cited WIC and the childcare assistance program as two potentially compatible programs given the Medicaid agency’s familiarity with both organizations and the similar eligibility requirements. The state has not taken any formal steps towards planning or designing this fifth phase, however.

Health Reform. Key informants emphasized ELE’s positive role in preparing the state for implementation of the Affordable Care Act. In particular, they suggested that ELE has increased the comfort level with interagency data sharing for both state officials and local eligibility staff, garnering critical buy-in as the state moves forward with electronic data sharing and verification required under the Affordable Care Act. Before the Supreme Court decision in June 2012 that effectively made the Medicaid expansion optional for states, Alabama had planned to pursue ELE for adults eligible under the Medicaid expansion. But now that the state has decided not to expand Medicaid in 2014, the issue is moot. In the future, if the state chooses to adopt this expansion, state officials believe they would also adopt ELE to quickly and efficiently enroll hundreds of thousands of eligible adults.

7. Lessons Learned

Several key lessons can be drawn from Alabama’s experience implementing Express Lane Eligibility. These include:

**Using a phased-in approach allows for critical buy-in from stakeholders and can help make ELE a success.** Alabama’s phased-in approach was advantageous in a number of ways. The earliest phases required virtually no upgrades or investments in IT, so they could be implemented quickly and with less effort than later phases. This allowed the state to prepare for Phase Three, which required the most significant IT investment. The agencies could also quickly identify and address issues in one phase to ensure that it was operating as intended, before moving on to more intensive phases. Perhaps most importantly, implementing ELE in phases gave the state time to gradually “ease in” to increased automation, allowing Medicaid agency staff—who may be hesitant to embrace sweeping changes to eligibility and enrollment processes—to become more familiar with it over time.

**A good existing relationship between state agencies and longstanding support from a coalition of stakeholders enables quick responses to new policy options.** Alabama’s Covering Kids and Families coalition—made up of a diverse group of stakeholders, including officials from both of the agencies involved in ELE (Alabama Medicaid Agency and the Department of Human Resources)—provided a forum for talking through ELE planning and design issues, allowing the state to move quickly to adopt and begin ELE implementation after CHIPRA passed. Though the
partnership between Alabama Medicaid and DHR was strengthened through CKF, key informants indicated that the two agencies already had a history of working together, which facilitated ELE implementation. DHR was a very willing partner and—as a social service agency—has a similar mission to Alabama Medicaid and saw the value in helping their clients obtain medical assistance. Additionally, the state’s longstanding commitment to covering children—facilitated by the CKF coalition—set the stage for further innovations and interagency cooperation, including ELE.

**Using ELE for children only may have limited effectiveness in states like Alabama, where the Medicaid case unit is the entire household and enrollment/renewal for any adults on the case must be processed in the traditional manner.** To address this limitation, Alabama pursued an ELE process for women in Plan First, the state’s limited-benefit Medicaid family planning program. After receiving approval under its 1115 waiver in 2012, Alabama became one of the only states to use ELE for adults. Since many households with Medicaid-covered children also include a woman on Plan First, implementing ELE for both coverage programs allows the entire family’s case to be renewed automatically, creating greater administrative efficiency and an easier application and renewal process for families.

**Automated ELE processes lead to greater administrative savings and increased efficiency.** Despite the recent implementation of Phase Three, Alabama officials had already witnessed considerable savings due to the time Medicaid eligibility staff had saved because they did not have to manually process redeterminations. Programming costs for the third phase were relatively minor (around $23,000 according to key informants) and mostly funded by existing state grants. Although it is too early to officially report, Alabama officials anticipate administrative cost savings of $1.1 million per year. These savings are particularly beneficial given Alabama’s lean staffing model, budget-related hiring freezes, and recession-related growth in caseloads.

**A nuanced approach to training—tailored to the perspective and concerns of the target audience—is important for ELE’s success.** ELE is a complicated concept that must be thoroughly explained to agency staff who will be involved in implementation and to key stakeholders (like the medical advisory committee or physician’s taskforce) whose support is crucial. Likewise,

---

**Focus Group Box #5: Implications of Having Health Insurance**

*Parents were grateful for having Medicaid coverage for their children.*

“It made a whole lot of difference.”

“It’s a big help.”

“It’s made a great difference.”

“You know they are covered. If you don’t have anything for yourself, at least you know they’re protected.”
Alabama officials recognized the importance of tailoring training to the needs of the Medicaid eligibility workers, using a message that focused on how ELE would make eligibility workers’ jobs easier and reduce their caseloads to more manageable levels. This message became more effective as caseloads grew and resources became more strained. It also helps to focus on getting the buy-in of “veteran” eligibility workers, who in turn may be able to influence the other workers and encourage their support of the initiative. Key informants also emphasized that training and educational efforts must be sustained over the course of implementation, rather than a “one-shot” approach.

8. Conclusion

Alabama’s long-standing commitment to children’s coverage, and the collaboration among state agencies, advocates, and other stakeholders in the Covering Kids and Families Coalition, allowed the state to quickly implement Express Lane Eligibility after the passage of CHIPRA. To facilitate a quick implementation and promote buy-in from state officials and eligibility staff, the state chose to implement ELE using a phased-in approach, continuously building off of and improving on previous phases. Although the state has only implemented the first three of five planned ELE phases, key informants are satisfied with the initiative’s outcomes. More than 400,000 enrollees have benefited from ELE at enrollment or renewal, and the state anticipates more than $1.1 million per year in administrative costs savings resulting from the newly implemented automated ELE renewal process. Despite the uncertainty surrounding the implementation of the remaining two phases, state officials remain committed to ELE and similar streamlined automated approaches in the future, particularly as the Affordable Care Act is implemented.
Works Cited


Kaiser Family Foundation. “Alabama State Health Facts.” Available at: http://kff.org/statedata/?state=AL
