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Policy Research

CHIPRA Express Lane Eligibility Evaluation

Case Study of Iowa's Express Lane Eligibility Processes

Final Report

August 23, 2013

Ian Hill
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HEALTH MANAGEMENT ASSOCIATES

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CONTENTS

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TABLES

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EXECUTIVE SUMMARY

Iowa currently operates two separate Express Lane Eligibility (ELE) processes. First, the state uses a system of referrals between Medicaid and the state's Children's Health Insurance Program (CHIP)—called *hawk-i*—that began five years before the passage of the CHIP Reauthorization Act (CHIPRA) and the formal federal authorization for ELE. Specifically, applications of children who are found ineligible for Medicaid due to excess income are sent to the CHIP program, where they are processed without asking families to reapply or resubmit information. In 2010, Iowa implemented its second ELE process between the Supplemental Nutrition Assistance Program (SNAP) and Medicaid. In contrast to the Medicaid/CHIP referrals, the SNAP/Medicaid ELE process functions as an outreach mechanism rather than an auto-enrollment system. Specifically, families that enroll in SNAP who have children that are not on Medicaid are sent a form offering Medicaid coverage for their children; the form must be completed and returned to the state Department of Human Services (DHS).

Pursuing ELE in Iowa was consistent with the state's long commitment to children's coverage. The legislature passed important legislation in 2009, which pressed the goals of universal children's coverage and directed DHS to implement all feasible enrollment simplifications encouraged by CHIPRA, including Express Lane Eligibility, so that Iowa could qualify for performance bonuses.

As described by Iowa officials, the state has taken a relatively conservative approach to the design and implementation of its ELE processes. For instance, officials chose to not fully automate enrollment of uninsured children in SNAP households into Medicaid. Rather, SNAP families with Medicaid-eligible children are sent a form that first asks parents if they'd like to enroll their children into Medicaid, and then goes on to inquire about other sources of health insurance, whether parents would like to request child support recovery assistance, and (in some cases) citizenship verification. To date, only about 13 percent of families have completed and returned the form. The state also chose to not utilize ELE for renewals to minimize error rates and confirm each child's ongoing eligibility for Medicaid.

The state did implement a fully-automated referral process between Medicaid and *hawk-i,* which eliminated the need for families to submit further documentation. As such, enrollment through this ELE mechanism is much more common; in 2011, *hawk-i* received 9,561 referrals from Medicaid, totaling almost 25 percent of total CHIP applications received. However, DHS chose not to adopt an express referral process that works in the opposite direction—from *hawk-i* to Medicaid—because it preferred to retain responsibility for the full Medicaid eligibility review process.

Table ES.1. Key Facts About Iowa's ELE Processes

Policy Simplification Adopted?	ELE process for *hawk-i*	ELE process for Medicaid
Policy adopted in Medicaid, CHIP, or both?	CHIP	Medicaid
Processes affected? (enrollment and/or renewal)	Enrollment only	Enrollment only
Implementation date?	July 2004, automated in 2005, approved as ELE in 2011	June 2010
Partner agencies?	Medicaid (Department of Human Services)	Supplemental Nutrition Assistance Program (Department of Human Services)
Is the simplified process different from the perspective of the enrollee/applicant?	Yes; applicant paperwork is reduced as families found to be ineligible for *Medicaid* are not required to reapply for *hawk-i* or submit further documentation	Yes; applicant paperwork is reduced as families are only required to return a form stating they would like coverage for their children; no further action is necessary
Faster time to coverage for applicants?	Yes; eligibility determinations are typically made in 5 days for a referral, while standard applications can take up to 30 days; coverage begins on the date of the Medicaid application	Yes; eligibility determinations are typically made in 2 days for a returned ELE form, while a standard application can take up to 30 days
Any time savings for the state?	Yes; MAXIMUS eligibility workers are able to make a decision on a referral in 6 minutes compared to the 20-30 minutes needed to process a standard *hawk-i* application	Yes; it takes Medicaid eligibility staff 12 minutes to process an ELE application, while a standard application takes about 40 minutes
Estimated cost to implement?	$33,000, including a one-time payment of $7,625 to MAXIMUS, and costs to the state	$84,000 initial investment to make necessary upgrades to the state's data system for the SNAP to Medicaid exchange; ongoing costs of $12,000 per year
Estimated ongoing net costs or savings?	Exact savings and costs per application could not be calculated	Mathematica's analysis, as presented in the Interim Report to Congress, indicates that Iowa's ELE process from SNAP to Medicaid is essentially cost-neutral

Many of the successes and challenges experienced by Iowa may be useful to other states pursuing similar processes under health reform. In particular, states should be aware that meeting the federal requirement of affirmative consent for enrollment by asking parents to complete and submit a separate ELE form, rather than automating enrollment, may reduce the potential number of ELE enrollments. Furthermore, the design and length of the form must be considered carefully, as longer and more complex documents might discourage families from responding. Finally, the lack of any broad-based outreach to Iowa families publicizing the new ELE option also could have contributed to a low response rate.

Nevertheless, given an already low uninsurance rate amongst children in the state, Iowa's ELE processes have served to reach some of the few remaining uninsured. One reason for this is the compatibility of the partner programs. Specifically, informants noted that SNAP and Medicaid are particularly compatible given the programs' similar income eligibility limits.

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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 two ELE simplification strategies implemented in Iowa:

- The first process automatically refers the applications and information for children who do not qualify for Medicaid to the state's CHIP program (*hawk-i*), and automatically enrolls them once they are determined eligible based on the income information already provided on the Medicaid application form.

- The second process offers expedited Medicaid enrollment to families with children under the age of 18 after they are enrolled in food assistance under the Supplemental Nutritional Assistance Program (SNAP). A daily data match is conducted by the Iowa Department of Human Services—which houses both Medicaid and the food assistance program—to identify children enrolled in SNAP who are not enrolled in Medicaid. All families with such children are then sent a form inviting them to enroll their children into Medicaid coverage based on their SNAP eligibility. Enrollment is not automatic; parents must complete and return the form to affirmatively indicate their desire to enroll the child in Medicaid.

To learn about these two ELE mechanisms, staff from the Urban Institute and Health Management Associates conducted a site visit to Iowa in December 2012, interviewing 16 key informants over a three-day visit to the state. While on site, the research team also conducted two focus groups with parents of children who had been enrolled via these ELE strategies in two locales—Des Moines and Knoxville. Through these focus groups, parents shared their experiences with ELE and traditional enrollments for Medicaid and *hawk-i,* as well as their experiences obtaining health care services for their children.

2. State Context: Why Pursue ELE?

Iowa has long been a committed leader in children's coverage. Since the establishment of its separate CHIP program—called *hawk-i*—in 1999, the state has made steady progress in reducing the number of children without health insurance through a combination of income eligibility expansions (for both *hawk-i* and Medicaid) and enrollment simplification efforts. Like many states, Iowa's pattern was to first adopt simplifications under its popular CHIP program, and then modify Medicaid to bring its rules for children's coverage into alignment with CHIP. This process was streamlined by the fact that both programs have always been administered by the same agency—the Department of Human Services (DHS)—which also runs Iowa's other family support programs, including SNAP, the Temporary Assistance for Needy Families (TANF) program, and childcare subsidies.

By 2007, more than 90 percent of all children in the state were insured—counting both private and public sources—and momentum was growing to achieve universal children's coverage. Governor Chet Culver, a Democrat, had campaigned on a platform advocating for coverage of all children, and Democratic majorities in both houses of the state legislature worked with their Republican counterparts to establish the Iowa Health Care for Small Businesses and Families Commission (the Commission) to review, analyze, and make recommendations on strategies for improving the affordability of health care for Iowans. Meanwhile, a leading public policy research group in the state—the Child and Family Policy Center (CFPC)—received a "finish line" grant as part of the David and Lucile Packard Foundation's *Insuring America's Children* initiative, designed to support state advocacy efforts toward achieving universal children's coverage.

The legislature passed House File (HF) 2539, legislation based on the recommendations by the Commission, by the end of the 2008 legislative session. The bill included: a *hawk-i* expansion to cover children up to 300 percent of the federal poverty level (beginning July 2009); 12-months continuous eligibility for children on Medicaid (effective July 2008); a provision that state income tax forms (beginning with tax year 2008) include a question that would allow parents to indicate whether or not their children had health insurance, so that the state could follow up with families with uninsured kids and inform them of available coverage options; and an appropriation to support an outreach campaign publicizing the availability of expanded coverage under *hawk-i* and Medicaid. HF 2539 also mandated that DHS research ways to maximize enrollment and retention of children in Medicaid and CHIP in collaboration with other non-governmental organizations. The CFPC seized on this provision to suggest to DHS that the two organizations jointly host a child health "summit" to build partnerships and further explore strategies for enhancing kid's coverage. Convened in September 2008, the Summit was universally praised by key informants as an effective and productive event. Among other things, it brought in leading child coverage experts from across the country—including state officials from other CHIP programs—to speak with state policymakers and succeeded in "opening a lot of eyes" and energizing stakeholders on how to move forward (Draper et al., 2009).

By April 2009, two months after CHIPRA had been signed into law, Iowa's legislature passed Senate File (SF) 389 which built on HF 2539 to further press the goals of not only universal children's coverage, but also broader coverage for all Iowans. According to several key informants, the larger health reform agenda of SF 389—which was championed by Senator Jack Hatch—deflected attention away from the expansive Children's Health Care section of the law, allowing it to pass without much opposition in the legislature. Within the Children's Health Care section, SF 389 expanded Medicaid coverage of pregnant women to 300 percent of poverty, added supplemental dental-only coverage to *hawk-i,* and included a number of provisions designed to improve access and retention for children under Medicaid and *hawk-i.* Of most relevance to this evaluation, it directed DHS to implement enrollment simplifications encouraged by CHIPRA so that Iowa could qualify for performance bonuses, including joint application forms for the two programs, administrative renewals, Presumptive Eligibility, and Express Lane Eligibility.

State officials quickly recognized that they already had an existing system in place that could qualify as ELE: its automated referral process from Medicaid to *hawk-i.* However, to earn a CHIPRA performance bonus, ELE had to be implemented in *both* Medicaid and CHIP, which spurred the creation of the SNAP/Medicaid ELE process. Iowa did, indeed, qualify for a CHIPRA performance bonus in 2010 worth $6.7 million, and then again in 2011 for $9.6 million, by meeting Medicaid enrollment targets and having in place for both Medicaid and *hawk-i* the policies of: 12-month continuous eligibility, no asset test, no face-to-face interview, a joint program application, Presumptive

Eligibility, and Express Lane Eligibility. (These and other key facts about Iowa's *hawk-i* and Medicaid programs are presented in Table 1.)

3. Planning and Design: What Was Needed to Develop the Policy?

As noted above, DHS's pursuit of additional enrollment simplification strategies was directed by SF 389 and incented by the possibility of winning CHIPRA performance bonus funds. However, evidence that DHS has historically looked for ways to simplify the enrollment process for families is seen in its creation of an express lane-like system of referrals between Medicaid and CHIP five years *before* the passage of CHIPRA and the formal federal authorization for ELE.

As the single state agency responsible for managing Medicaid, *hawk-i,* SNAP, and other family support programs, DHS had a relatively straightforward path for planning its ELE system reforms. It also had complete control over deciding what options it should exercise in designing its specific versions of the strategy. Key informants described the management style of DHS as "conservative" and "careful," and those qualities are reflected in the ways in which ELE has been implemented in Iowa.

Medicaid-to-CHIP. In the case of its Medicaid-to-CHIP ELE strategy, Iowa was arguably years ahead of many states in designing a more efficient process for conducting "screen and enroll," efficiently referring Medicaid applicants found to be *hawk-i* eligible, and saving families the burden of having to reapply for coverage in CHIP after having already applied for Medicaid. And, in the years since this process was first launched in 2004, Iowa officials have refined and improved it, making it more automated.

Table 1: Key Facts About Iowa's Medicaid and *hawk-i* Programs

Program Name	• Medicaid • *hawk-i*
Upper income limits	Infants: Medicaid 133%, M-CHIP 300% 1-5: Medicaid 133%, CHIP 300% 6-18: Medicaid 100%, M-CHIP 133%, CHIP 300%
12 months Continuous Eligibility?	Yes
Presumptive Eligibility for Children?	Yes
In-Person Interview Required?	No
Asset Test?	No
Joint Medicaid and CHIP Application and Renewal Forms?	Yes[a]
Premium Assistance Subsidies?	Yes, Health Insurance Premium Payment Program (Medicaid)

Program Name	• Medicaid • *hawk-i*
Adult Coverage	• Unemployed parents of dependent children with incomes below 27% FPL, and working parents with dependent children with incomes up to 80% FPL are eligible for Medicaid • All adults without earned income below 200% FPL, and all working adults with earned income up to 250% FPL are eligible for limited coverage under the IowaCare waiver program
Renewal Processes	• Medicaid: Families are sent a partially pre-populated renewal form about a month before coverage expires and must return the form and any necessary documentation. • *hawk-i:* Families are sent a pre-populated renewal form two months before coverage expires and must return the form and any necessary documentation. Online renewal is also available.
Delivery system	• Medicaid: Managed care (primary care case management) • *hawk-i*: Managed care with commercial managed care health and dental pans

Sources: Site Visit Interviews, Heberlein et al. 2013, Kaiser Family Foundation State Health Facts
[a]Although the state does not utilize a single joint application, it has a no wrong-door policy so CHIP and Medicaid accept either application.

DHS's conservative management approach toward ELE is seen in that no CHIP-to-Medicaid correlate exists to mirror the Medicaid-to-CHIP referral process. State Medicaid officials—in an era before Express Lane Eligibility was even an option—were not willing to take the risk of accepting the eligibility determinations of a CHIP vendor as sufficient for Medicaid. Rather, to maintain program integrity and minimize error rates, Income Maintenance Workers (IMWs) perform their own eligibility review of information submitted to *hawk-i* by families. To its credit, DHS has done just about everything short of automating the CHIP-to-Medicaid referral process; most important, the agency has stationed DHS IMWs on site at MAXIMUS—*hawk-i's* third party vendor—to electronically receive applications that are submitted to *hawk-i* and evaluated as likely to be Medicaid eligible, so they can receive streamlined processing, with minimum delay or burden for additional information from the families.

After the passage of CHIPRA, Iowa officials inquired with CMS as to whether its Medicaid-to-CHIP referral system could qualify as ELE, since it was automated and designed so that virtually no additional information would need to be obtained from families. After some back and forth, CMS responded favorably and a state plan amendment anointing this system as ELE was granted in June 2011.

SNAP/Medicaid. The choice of the SNAP program as the ELE "partner" for Medicaid was a natural one. SNAP is administered within the same agency as Medicaid, and the program's upper income eligibility threshold was close to that of Medicaid's for children. Eligibility determination for SNAP is performed by the same IMWs that determine eligibility for Medicaid, so their cross-program expertise in eligibility rules and demonstrated high quality/low error performance was a significant factor in selecting the SNAP as the "partner". Finally, the 30 year-old legacy computer system that the two programs share allows IMWs to run matches of Medicaid and SNAP files to identify children in SNAP households who are not enrolled in Medicaid.

At the same time, state officials (and local IMWs) were concerned enough about using one program's eligibility rules to substitute for another's—given differences between the programs' methods for counting income, defining households, verifying family characteristics (among others)—that they did not adopt a fully automated ELE program, nor did they think it appropriate to use ELE for *both* initial enrollment and renewal.

State officials chose not to use ELE for renewing children's coverage, explaining that, given Medicaid's 12-month continuous eligibility policy, coupled with the possibility that some children were initially qualifying for Medicaid via ELE who might not exactly meet the program's eligibility rules, they preferred to use Medicaid renewal as an opportunity to revisit each child's eligibility for coverage and confirm their ongoing eligibility. This decision was also made because federal officials had not yet provided states with specific information on how they might audit ELE programs for errors. This meant that children initially enrolled via ELE would go through the normal Medicaid renewal process, rather than a streamlined, ELE version of renewal.

With regard to the program's level of automation, DHS officials said they followed federal rules that say families should be made aware of their options, rights, and responsibilities before being enrolled in a new program, and therefore should actively consent to their children's enrollment into Medicaid via ELE before coverage is put in place. Their interpretation of this requirement led to the adoption of an ELE process that serves as an outreach tool to identify children who *could be* enrolled in Medicaid without further application, *if* their parents accepted the offer of coverage.

This conservative approach carried over to Iowa's design of its SNAP/Medicaid ELE application form. DHS designed a form that, on the first page, asks parents if they would like to have their SNAP-eligible children enrolled in Medicaid. In subsequent optional pages, the form goes on to ask parents if their children already have other forms of insurance, if they'd like help from the state in obtaining child support from an absent parent, and, to submit citizenship (or legal residence) verification only in cases where this status has not already been previously verified. Four to six pages in length, the form's appearance of complexity might have contributed to a rather tepid response from parents to the invitation to enroll their children into health coverage (described in more detail below), though stakeholders had varying opinions on this issue. When

asked why they designed the form in this way, state officials replied that it was an "efficient" way to go, since they were already contacting parents, needed this information, and did not want to send multiple letters to families.

As Iowa got ready for its SNAP/Medicaid ELE launch, a simple training module was developed that was presented to central office staff as a workshop, and broadcast by webinar to DHS staff in local offices across the state. The training explained the new policy, described the new form that would be sent to families with ELE-eligible children, and demonstrated the modifications that were being made to the eligibility computer system that would require IMWs to input "ELE" identifiers on child cases enrolled via this method. Key informants at the state and local level described the training as clear, straightforward, and helpful.

Even with a 30 year-old legacy system, system changes required by ELE were minimal for DHS. Specifically, state officials developed an automated process to issue forms to families with such children and invite their enrollment in Medicaid; and added codes to the eligibility system to identify children as ELE eligible, and as ELE enrolled. The eligibility system changes were carried out over the months preceding the launch of ELE.

Meanwhile, gaining federal approval for its SNAP/Medicaid ELE plan amendment was also described as smooth and unremarkable, although Iowa staff described what it considered a lack of guidance from CMS while the state was developing its amendment and seeking input from federal officials. DHS submitted its proposed State Plan Amendment in April of 2010 and received approval in June 2010.

4. Implementation: What Happened?

Iowa's experiences implementing its two ELE processes are detailed below. Discussion of outreach for *hawk-i* that has occurred in recent years, though not specifically promoting the state's ELE efforts, is also presented.

Medicaid-to-hawk-i ELE Process. The first ELE mechanism that Iowa implemented involves the automatic referral of children in families that apply for or renew their Medicaid coverage—but are found to have income exceeding Medicaid's thresholds—to the state's CHIP program, *hawk-i*. Prior to automation, Medicaid IMWs were required to complete a paper *hawk-i* referral before manually sending applications of children determined to be over Medicaid income limits to *hawk-i's* eligibility vendor, MAXIMUS. Key informants reported that during this process, applications were occasionally lost or, at times, not even sent due to heavy caseloads, and eligibility staff at both MAXIMUS and DHS described this manual process as administratively very burdensome. It wasn't until the state developed the online application in 2005 that an electronic automated referral process could be implemented between the two programs. Automation of the process was cited by key informants as a tremendous improvement that has resulted in a substantial increase in the number of applications that are referred from Medicaid to CHIP.

When the system referral was first automated, IMWs were responsible for making an eligibility determination before pulling up the referral screen. Today, however, the referral screen pops up automatically after a family's income is put in the system and determined to exceed Medicaid levels, eliminating the need for the IMW to first make a full Medicaid eligibility determination. In addition to income, information from the Medicaid application related to citizenship, identity, Social Security number and insurance status automatically populates the referral screen. IMWs are given a chance to provide comments about the child, reasons for ineligibility, and how income was determined, before sending the referral through a secure file transfer to MAXIMUS. MAXIMUS is still required to evaluate the application to make a final determination about eligibility for *hawk-i*, but does so with the information provided by Medicaid and is not required to request any additional information from families. In other words, the income and other information used to determine Medicaid ineligibility is the same used to determine CHIP eligibility.

The Medicaid-to-CHIP referral process typically requires no input or consent from families; state officials decided that, since families were already applying for or renewing their enrollment for medical assistance, additional consent to be considered for *hawk-i* was not necessary. At the time the referral take place, however, families are sent a letter alerting them that they no longer qualify for Medicaid but will be considered for enrollment in *hawk-i.* Additionally, families initially applying for Medicaid may be contacted by MAXIMUS staff to provide proof of insurance cancellation before a final CHIP eligibility determination can be made. Once a child is approved for *hawk-i*, families are sent an approval letter that instructs them to select a health plan, and provides general information on the program.

As was discussed above, Iowa does not have an automatic referral process in place that works in the opposite direction—from *hawk-i* to Medicaid—when families applying for *hawk-i* are found to have low enough income to qualify for Medicaid. Consistent with standard "screen and enroll" requirements for CHIP, however, co-located Medicaid staff onsite at MAXIMUS do receive potential Medicaid-eligible applications identified through the "screen and enroll process," and formally review them for eligibility. If the family is already receiving other

Focus Group Box #1: ELE Compared to Traditional Application Process

Parents were very appreciative of the referral process from Medicaid to *hawk-i,* particularly when compared to the standard application process

"I was expecting to go through the same steps that I did with Medicaid…so I was very satisfied with it."

"I didn't fill out anything for hawk-i because they just transferred all of my information [from Medicaid]. It was really easy, really simple."

"The [referral] made it a lot easier…it took a big load off of my mind."

public assistance such as SNAP, the application will be passed along to local DHS offices for processing. Initially, this process was completely paper-based; however, today MAXIMUS electronically scans any paper applications before sending them on to Medicaid workers, making the process completely electronic. Thus, while this referral process is similar to Medicaid-to-CHIP ELE, it differs in that Medicaid coverage is not automatically granted—IMWs cannot rely on CHIP income determinations, must review the applications themselves, and often have to request additional information or documentation from families.

The number of applications and renewals that are handled via the Medicaid-to-CHIP ELE process is far larger than that of the SNAP/Medicaid process (discussed below), with individual eligibility workers reporting they process "dozens of them" each day. When Medicaid-to-CHIP ELE was first implemented, IMWs received a one-hour training on the referral process, while MAXIMUS staff were sent a training manual electronically before receiving training via a regular monthly conference call to discuss the specific policy changes. Staff at both DHS and MAXIMUS are pleased with the automated Medicaid-to-CHIP ELE process, as it makes processing and determining eligibility easier and reduces the chance of user error.

SNAP/Medicaid ELE Process. The SNAP-to-Medicaid ELE process was implemented immediately after receiving approval from CMS in June 2010. The planning and design process—which involved moderate systems updates to DHS' 30-year old legacy system, the development of new consumer materials, and a small staff training component—led to a smooth implementation, according to state officials and other key informants interviewed for this case study. Indeed, the process has remained unchanged since 2010.

To apply for any DHS program, families must complete an application with separate components for all of Iowa's health and human services programs, including Medicaid, SNAP, cash assistance, and child care subsidies. Eligibility staff located at local DHS offices across Iowa's 99 counties are responsible for determining family eligibility for these programs, and families are free to apply for all, one, or any combination of programs using the single form. Applications can be submitted online, by mail, or at local DHS offices. Once applications are submitted, IMWs verify income, identity, and citizenship, before conducting phone or in-person interviews with families, in situations required by law.

For families found eligible for SNAP, DHS' data system runs a daily automated match against Medicaid records to identify children, under the age of 18, who have not been enrolled in Medicaid within the past two months, and who are thus eligible via ELE for Medicaid. The computer system adds a code on the case files of these children and then automatically generates a four- to six-page form that is mailed to parents offering Medicaid to eligible children and requesting additional information (see Appendix A). The first page of the form says:

"NEW rules make it easy to get Medicaid for the children in your home who already get Food Assistance. You will not have to fill out an application."

The names of the family's eligible children are then listed, and parents are asked to check either "yes" or "no" next to each child's name, and sign and date the form. To gain coverage through this ELE mechanism, parents must complete this page and return it to DHS within 30 days.

Subsequent pages of the form are optional, though nothing on the form itself explains this. Page two asks: whether or not children have other forms of insurance; whether children have received medical care in the prior three months and, if so, do families want help paying for medical bills associated with that care; and whether parents want to get help from the state's Child Support Recovery program for children named on the form. (If parents say "yes" to this last question, they are asked to identify and provide names, birth dates, Social Security numbers, employers, and addresses for parents not living in the home.) Pages three and four of the form are designed to collect detailed information (when relevant) about existing health insurance policies and who's covered by them. When needed for children who previously were not verified as citizens via the automated SVES match, the last two pages ask whether children listed on the form are U.S. citizens or qualified aliens and provide detailed instructions on how families can obtain proof of citizenship for their children.

Focus Group Box #2: SNAP/Medicaid ELE Compared to Past Application Processes

Parents who had experience applying with Medicaid and SNAP in the past felt the process had improved greatly over the last several years.

"*It used to be a lot tougher."*

"I think it's all hooked a lot better electronically…with your food stamps or what not, that's all connected."

"I think it's really easy, really simple…I just went online…and then they called us to do an interview over the phone…and that was it. I thought that the process was really easy for me."

If a family returns the form, the application is put in the work queue of an IMW, who is responsible for putting a separate code in the system indicating that the child was approved via the ELE process. IMWs must manually enter information from the ELE form into the system, and request documentation of citizenship from parents if they are unable to verify it through an SSA data match. Families are then sent a notice of decision regarding their children's new coverage before receiving their Medicaid card from member services within 7-10 days. If a family does not return the ELE form within 30 days, their opportunity for ELE for Medicaid is automatically closed in the DHS system.

There have been few appreciable changes to the daily responsibilities of IMWs with the implementation of SNAP/Medicaid ELE. Overall, IMWs reported a low volume of ELE applications initiated as SNAP applications. Consequently, no additional IMWs have

been hired to facilitate the processing of ELE applications, as there were sufficient "family team" staff members at each local DHS office who could be trained to be capable of processing both standard and ELE applications.

In response to DHS's initial ELE training for local staff, there was some initial hesitation among IMWs that the new ELE process would be time consuming and underfunded. Moreover, during a workgroup with DHS local supervisors, IMWs, and state central office managers, some staff expressed concern that families might be incorrectly deemed Medicaid eligible through ELE due to the differences in requirements between SNAP and Medicaid. However, over time, these concerns have largely dissipated as IMWs have adjusted to the new policy and ELE has ultimately resulted in very limited additional work for IMWs.

Importantly, eligibility staff also noted that the nature of the new ELE work was consistent with their underlying mission to sign families up for all of the benefits they qualify for and can benefit from. Indeed, one DHS local supervisor maintained that they "were already covering this" because they always "look at the big picture" when sitting down with a family and reviewing their applications, exploring whether or not they would like to apply for any other programs on the DHS form. With increases in the number of applications being submitted online, however, eligibility workers are having less direct influence on which programs families ultimately apply for, making the ELE Medicaid "follow-up" option potentially more important. On the other hand, there are many misperceptions families have about Medicaid eligibility—such as the ability to have Medicaid while also having other forms of health insurance—that eligibility workers are not able to clarify when families fill out applications online.

Iowa does not use its SNAP/Medicaid ELE process for children's renewals of coverage (as discussed in Section 3). Key informants asserted that a more thorough review of an applicant who came in through the food assistance pathway was necessary at the one-year anniversary of coverage to ensure that children were still truly eligible for Medicaid, due to concern over future CMS audit criteria. In fact, officials implied that there was some remaining concern that certain families who are receiving Medicaid based on their SNAP eligibility would not technically qualify for the program if the eligibility had been processed by standard Medicaid requirements, as there are some differences in the income determination methodology between SNAP and Medicaid. Additionally, state Medicaid and CHIP administrators noted that, with lack of detailed guidelines regarding how CMS would calculate error rates, the state has been cautious about ELE enrollment in Medicaid to avoid punitive action by CMS down the road.[1]

***Outreach for ELE**:* There have been no specific outreach efforts to promote either of the two Express Lane Eligibility processes in Iowa, a gap noted by several key

[1] At the time of this writing, CMS had not yet released any further guidance on the calculation of error rates.

informants. Rather, the state's CHIP program has engaged in several broader outreach efforts in recent years to promote *hawk-i*, as described below.

The *hawk-i* program has pursued four primary outreach efforts in recent years, and has worked to track the efficacy of these efforts on the application itself. The largest marketing effort occurred in 2009, when *hawk-i* launched a large scale media campaign to raise awareness of the new policies enacted that year by the state legislature, including the expansion of *hawk-i* eligibility to 300 percent of poverty and the newly implemented dental-only program. Key informants reported that the campaign was a great success, as enrollment numbers increased substantially.

Additionally, *hawk-i* has long contracted with the Iowa Department of Public Health to support grassroots outreach in local communities. This contract, which amounts to roughly $380,000 annually and has not changed in recent years, pays (at least in part) for 22 outreach coordinators across the state who are tasked with developing outreach plans for their regions and communities. Particular emphasis is placed on outreach to schools, faith-based organizations, businesses, providers, and specific ethnic and cultural populations in their community. Additionally, outreach coordinators provide application assistance to families and are responsible for filing Occurrence Reports with DHS if families have any issues during the application process. More recently, the outreach coordinators have focused on promoting Presumptive Eligibility to application assistors across the state and have certified over 200 "qualified entities" who now help families complete the two-page Presumptive Eligibility application, grant temporary coverage, and submit the form to DHS for follow-up to establish ongoing Medicaid or CHIP coverage.

Informants also identified two additional referral activities as part of their overall outreach strategy. First, under state law, *hawk-i* is required to work with the Department of Revenue to try and identify and reach uninsured children. Since 2008, the state income tax form has included a question parents are required to answer: "Do you have insurance for your children, yes or no?" If the family indicates that they do *not* have insurance for their children, the Department of Revenue checks their income to see if they might be *hawk-i* eligible. Families found to be within the *hawk-i* income limits are sent a letter by the Department of Revenue informing them that their children might be eligible and suggesting that they call the program's toll-free customer service center for more information. (While states like Maryland and New Jersey have received federal approval of similar systems as ELE, Iowa has never thought of its tax-based referral process in this way.) Officials noted that this strategy has not been very productive, stating that only a limited number of enrollments have occurred as a result of tax-form referrals. These officials also reported that families tell them that the question on the tax form is confusing, and some have recently remarked that they think it is a strategy to enforce the individual mandate under the ACA. Consequently, *hawk-i* is attempting to work with the tax office to rewrite the question in an effort to solicit a greater response. So far, however, these efforts have been met with resistance.

The second referral strategy targets families when they fill out an application for the National School Lunch Program (NSLP). On the school lunch form parents are offered an opportunity to opt-out of being referred to Medicaid or *hawk-i*, and informed that if they do not opt-out, their information will be shared with DHS. A third party administrator receives the names of children from each school before sending out a letter to parents notifying them that their children might qualify for *hawk-i* and to call the customer service center. This opt-out effort has been in place since 2007, and while today nearly all schools do provide this option on their NSLP application, the effort was not implemented consistently, and few schools complied.

In all, both the tax form and NSLP outreach efforts are not perceived as particularly effective. In response to the "how did you hear about us" question on the CHIP application, only 250 applicants in 2011 replied that they heard about the program through the state income tax form, while only 106 responded that they heard about it from the NSLP (see Table 2). In contrast, more than 18,000 people responded that they heard about the program through the Department of Human Services.

Table 2: *hawk-i* Outreach Strategies, 2011

How did you hear about *hawk-i*?	**Number of applicants**
Billboard	370
Church	93
Community Organization	10
Daycare	223
DHS	18,147
Doctor/pharmacist	1267
Employer	662
Free & Reduced price meals	106
Friend or Relative	5,926
Health or Social Agency	540
Insurance Agent	5
Internet	6
Newspaper	92
Radio	668
Renewal	939
School	2,327
State income tax form	250
TV	2,890
WIC Program	679
Unknown	7,395
Other	1,432

Source: Cost interviews described in Hoag et al., 2012.

Note: This data does not include information from applications submitted online, which now account for 50% of all applications submitted.

5. Outcomes: What are the Observed Outcomes?

There are several varied outcomes that can be attributed to both of the ELE processes Iowa has implemented over the last several years, including increased enrollment, cost savings, administrative efficiencies, and client satisfaction. Each of these outcomes is discussed below.

Medicaid-to-*hawk-i* ELE outcomes

Enrollment: Key informants universally praised the automated referral process between Medicaid and CHIP, citing the ease of the process for parents and its benefits in facilitating the exchange of information between the two programs. Prior to the automation of this process, *hawk-i* was receiving approximately 400 referrals from Medicaid per month; following automation that number more than doubled to 838 referrals per month. In 2011 alone, *hawk-i* received 9,561 referrals from Medicaid, totaling 24.5% of total applications received.

Program Costs and Administrative Savings: For the Medicaid-to-CHIP ELE process, systems changes associated with automating the process and modifying the previously implemented on-line application process to accept referrals cost the state $33,000, including a one-time payment to MAXIMUS of $7,625, with the balance required to update the state's computer system to allow the referral to take place. In addition to these initial investments, MAXIMUS staffing has been increased over the past several years to handle growing *hawk-i* enrollment. Initially, MAXIMUS and the state estimated that two additional staff would be needed to accommodate ELE referrals. Notably, when automated referrals were implemented, the *hawk-i* program had 6,000 enrollees, and the program has since grown to 38,000. Over the period of 2005 to the present, many eligibility and enrollment polices have changed, making it difficult to pinpoint the marginal extra work or efficiencies resulting from ELE implementation. Because this process has been in place since 2004 and has no comparative procedure (a manual process), exact savings and costs per application could not be calculated.

Overall, however, the Medicaid-to-CHIP ELE process takes much less time for workers to process than

Focus Group Box #3: Client Perspective on CHIP Coverage

Several parents who received *hawk-i* coverage reported being initially concerned that the coverage would not be as comprehensive as Medicaid; and worried about the cost-sharing provisions in CHIP, while others were just happy to receive health coverage.

"I was used to [Medicaid]. I knew what they covered. I knew what to expect. So on this hawk-i, I'm like, oh, no what is not going to be covered?"

"I was afraid that it wouldn't cover as much or as well as Medicaid"

"On [Medicaid], they pay for everything…no questions."

"I didn't know the difference, and personally…my biggest concern is just as long as they're covered."

traditional *hawk-i* applications. Specifically, Maximus staff report that eligibility determination via this route takes only six minutes to complete, compared to the 20-30 minutes needed to process a standard application.

Improved Application Process and Client Satisfaction: The Medicaid-to-CHIP ELE process reduces the paperwork burden on families applying for medical assistance, as applicants are not required to reapply for *hawk-i* if found over-income for Medicaid, and often do not have to submit additional documentation. As such, families often receive eligibility determinations more quickly through the ELE referral process. Specifically, it takes about 5 days for a *hawk-i* eligibility determination to be made with a referral from Medicaid, whereas a standard application can take up to 30 days to process and complete. Moreover, because *hawk-i* uses the Medicaid filing date to establish eligibility, rather than the date of the *hawk-i* referral, coverage for families who enter *hawk-i* via the Medicaid referral route begins at an earlier date.

The automated referral process has also decreased the need for a family or application assistor to follow up with DHS to check on the status of their application. Initially, when the referral was still a manual process, local DPH outreach coordinators filed Occurrence Reports with DHS on a regular basis to report that a family's application had been lost between Medicaid and *hawk-i.* Over the last several years, however, outreach coordinators have seen a decrease in the number of Occurrence Reports, which they attribute to both the automation of the referral process and better staff training.

Consequently, consumers participating in our focus groups were universally pleased with the Medicaid-to-*hawk-i* ELE process. They consistently remarked that enrollment was a simple process that involved less work and mental energy on their part. Moreover, as illustrated in Focus Group Box #3, gaining enrollment provided families with peace of mind. Despite reporting general satisfaction with

Focus Group Box #4: Access in Medicaid and CHIP

Although most parents in Medicaid and *hawk-i* were very satisfied with their access to care and the quality of care their children received, many parents had trouble finding a dentist in their area and felt the dental coverage was not comprehensive.

"I had to go to University of Iowa in Iowa City…it's an hour and a half away"

"I think dental care is bad…because I just had to go down to Iowa City too. And I think that people that are already struggling financially…it's what $40 or $50 to go up there and back just in gas."

"[Hawk-i] only covered for some of their dental, and some of the things had a lot of stipulations on them."

"There's some places that didn't take [Medicaid] as dental so we've had some trouble."

"We were on [Medicaid] when it started with the braces. And then in the process of her braces…[we] switched to hawk-i. And I didn't realize that there's a $1,000 cap on the dental for a year for your children…I ended up spending $1,000 out of pocket."

hawk-i, some families were initially disappointed to not be enrolled in Medicaid, as many already had experience with the program and were therefore familiar with its coverage. However, these initial concerns disappeared as families gained experience with *hawk-i.* In fact, many parents with past Medicaid experiences expressed a preference for *hawk-i* because they believed it provided better access to providers. Similarly, while some parents initially worried about the financial burden of being enrolled in *hawk-i*—because they were not used to paying monthly premiums for their children's insurance—none felt that the premiums had been a financial burden, particularly in comparison to the cost of private coverage.

SNAP-to-Medicaid ELE outcomes

Enrollment: The SNAP/Medicaid ELE process has not been as successful in enrolling as many eligible children as the state initially hoped. DHS reports that since inception, while nearly 26,000 letters were issued to families inviting them to enroll their eligible children, only 3,391 forms were completed and returned—a response rate of only 13 percent.[2] When probed about possible reasons for the low response rate, key informants offered a number of explanations. Eligibility workers speculated that some families don't want Medicaid because they already have health insurance. Others reasoned that many families, new to public assistance as a result of job loss due to the Great Recession, might only want temporary assistance with food and resist accepting more forms of what they might consider welfare. In addition, sometimes the SNAP and the Medicaid households are composed differently, and a temporary guardian seeking food assistance may not want to get involved with the child's medical coverage needs.

However, several stakeholders believe that the consent process that Iowa designed, which involves a four- to six-page form that parents are asked to fill out and return to DHS, represents a significant barrier in its own right and may have contributed to the low response rate. While almost all informants mentioned that the long form could be seen as overwhelming and onerous to families, several also made particular note of the questions focused on child support recovery. Although these questions are optional, nowhere does the form state that they are optional. Therefore, it is likely that some parents could be deterred from completing and returning the form out of confusion or fear that the state might pursue child support from an absent parent. Similarly, the additional questions and pages related to other sources of health insurance were described by some as imposing.

To improve rates of ELE enrollment, some informants suggested that a better approach might be to allow parents to "opt-in" to Medicaid coverage (if found eligible for SNAP) on the initial food assistance application. But state officials said they believed families need to be informed and understand their rights and responsibilities related to a program before agreeing to share information for auto-enrollment. Some informants

[2] This number is not unduplicated; the same child could have been sent ELE forms more than once due to SNAP recertification every 6 months.

also suggested that the ELE form could consist only of the first page, simply asking parents—yes or no—if they wanted Medicaid coverage for their kids. These informants suggested that the state could then follow up with the additional questions related to child support and other insurance at a later point.

Program Costs and Administrative Savings: For the SNAP/Medicaid process, approximately $84,000 was initially invested in making upgrades and changes to the state's data system—this involved establishing the algorithms that would allow for automatic data matching between Medicaid and SNAP, producing the automated letter to parents with eligible children, adding codes to the system that identify a child as ELE eligible, and identifying children enrolled through the process. Ongoing costs for SNAP/Medicaid ELE total roughly $12,000 per year, and include the costs associated with sending letters (approximately $2.35/letter including the stamp, form and envelope), and an additional $1.15 if a letter is filled out and returned.

Since they had been working with a legacy system that is not particularly nimble, state officials ultimately decided not to fully automate the SNAP/Medicaid process because it would have been too costly and time consuming to implement. IMWs are therefore still required to manually complete the enrollment process when ELE forms are returned. Nonetheless, ELE applications do take less time for IMWs to process compared to normal applications, as all of the information collected on the initial DHS multi-program application is already verified. Specifically, it takes approximately 12 minutes to process an ELE application once the family returns the letter, while a standard application, in contrast, typically takes between 20 and 30 minutes to process.

Analyses conducted by Mathematica Policy Research from the first year of the Express Lane Eligibility evaluation found that the SNAP/Medicaid ELE process was "cost neutral" from an administrative perspective, as added mailing costs and the initial technology investment essentially offset the time savings from processing successful ELE applications more efficiently than standard applications (Hoag et al. 2012). However, key informants

Focus Group Box #5: Client Perspective on the SNAP/Medicaid ELE process and Coverage

Parents were overwhelmingly satisfied with the Express Lane Eligibility process and expressed relief that their children had health coverage.

"I was happy to see it, because my kids had been without insurance…over the summer. And it's a load off of my mind."

"I think I would be lost if my kid didn't have insurance or a doctor to go to."

"I wasn't able to afford copays and the prescriptions for my children. So I felt blessed when I got the letter and received it. It was a lot of financial relief."

However, several parents expressed confusion about their Medicaid coverage.

"You get a letter, and then that's how I overlooked my son even having this insurance, because they put it all in this letter, and then I didn't realize what was going on."

"It was confusing to me…I did not know…that it covered his medication. That's $25 a month…it just wasn't clear."

also noted that there were significant opportunity costs associated with ELE, as staff time was devoted to bringing Medicaid and SNAP systems and policies in line.

Improved Application Process and Client Satisfaction: The SNAP/Medicaid ELE process provides families with a faster and more convenient enrollment experience than the traditional Medicaid application pathway. Families who received Medicaid via the SNAP ELE process said in focus groups that they were grateful for the automated process and appreciative of the reduced paperwork burden (see Focus Group Box #5). While this new process was unexpected for some, it represented a welcome change and relief from financial stress.

Initially, however, some families said they were confused at different points of the ELE process, as they were not applying for medical assistance to begin with and/or were not familiar with the Medicaid program. Although several key informants insisted that parents are not confused about their coverage because they must read, sign and return the form, one parent reported not knowing she had Medicaid coverage for her son for almost a year.

6. Looking Forward: Future Prospects for Using ELE

No significant future changes or expansions of ELE are expected in Iowa. This outlook exists within the context of the state's generally negative stance toward federal health care reform under the Affordable Care Act. The election of returning Governor Terry Branstad (R) in November 2010 ushered in a more conservative tone toward health coverage expansions; for example, in February 2013, Iowa joined 13 other states in declaring it would not expand Medicaid under the Affordable Care Act. Instead, Branstad is hoping to receive federal approval of a waiver application to implement the recently passed Iowa Health and Wellness Plan—a limited version of a Medicaid expansion—which would extend health coverage to adults ages 19 through 64 with incomes below 138 percent of poverty (Des Moines Register, 2013; The Gazette, 2013). Meanwhile, in December 2012, the Governor informed federal officials that Iowa would "reluctantly" pursue the establishment of a state-federal "partnership" health insurance marketplace, with the state assuming responsibility for health plan management, consumer assistance, and Medicaid eligibility determination, and the federal government managing the exchange website and call center, and funding the Navigator program (Kaiser Family Foundation, 2013). Generally, it is not clear whether ELE, or some variant of ELE for adults, could fit with the Affordable Care Act's requirement that the U.S. Department of Health and Human Services (HHS) develop a single, streamlined application that will be used to apply for Medicaid, CHIP, and subsidized coverage through health insurance exchanges (Centers for Medicare & Medicaid Services, 2012).

With regard to its current ELE systems for children, DHS officials said they were generally satisfied with how the strategies were working and had no immediate plans for changing them, especially since DHS recently hired an IT contractor to develop a new Medicaid and CHIP eligibility system to replace the current one that will have

interoperability capacity with an insurance exchange. They were comfortable maintaining the focus of SNAP/Medicaid ELE on enrollment only and were not planning on in extending it to Medicaid renewals. Nor were they contemplating simplifications to the ELE form currently sent to families, despite lower-than-anticipated response rates. With regard to Medicaid-to-CHIP referrals, DHS was also pleased with how that process was working and said they would continue it, as is, until larger eligibility system changes forced adjustment. More generally, state officials were pleased that the federal government's planned "sunset" for ELE authority was extended for a year past its previous 2013 end date so that they could maintain current operations.

7. Lessons Learned

Overall, DHS officials and other stakeholders are pleased with the progress being made through ELE strategies. Lessons learned by these informants included, that the SNAP program is a particularly good ELE partner program for Medicaid, given not only the programs' respective and similar income eligibility limits, but also their shared administrative authority, which makes data matching and program coordination simpler. CHIP, too, represents a good match for Medicaid, and federal "screen and enroll" requirements set up Iowa to develop a very efficient and automatic transfer of applications from Medicaid to *hawk-i.* Furthermore, an oft-cited benefit of ELE is that it helps reduce the chances that children are denied coverage for administrative and procedural reasons, by facilitating the transfer of application information from one program to another, and by relieving families of the burden of applying for coverage more than once. Directly related to this benefit, of course, is the decreased administrative burden on state eligibility workers and program administrators, as well as the reduced administrative cost that comes with an increasingly efficient application process.

Still, it seems that Iowa's ELE approach is not living up to its full potential. The SNAP/Medicaid ELE process, in particular, is only being used for initial enrollment of children into coverage, and not at renewal, which could reduce the chances that children inappropriately lose coverage and churn on and off coverage. Further, the decision to have parents actively consent to their children's ELE enrollment by completing and mailing back a form has resulted in a response rate of less than 15 percent and led to fewer Medicaid-eligible children enrolling into coverage than the state expected. The lack of any targeted outreach to families publicizing the new enrollment mechanism was also cited as a gap.

But it can be argued that, with a new option such as ELE, it has been wise to begin cautiously and to see how, and how well, the strategy works. And for those families who have benefited from ELE enrollment, they are very pleased with the simpler and less burdensome process they've experienced. In time, as new coverage programs emerge through reformed healthcare systems, perhaps more children and families will benefit from the lessons learned by states like Iowa that have tested new strategies for facilitating access to insurance.

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APPENDIX A

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Iowa Department of Human Services

Express Lane Medicaid for Children

County number: Worker name and number:

Case number: Worker phone number:

NEW rules make it easy to get Medicaid for the children in your home who already get Food Assistance. You will not have to fill out an application.

If you want Medicaid for your children:

1. Check "Yes" for each child named below that needs help with paying medical bills.
2. Sign and mail this form to your DHS office or bring it to the DHS office by _____.

Yes	No	Name of Child
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Your Signature	Date

Health Insurance

Do the children have other health insurance? ☐ Yes ☐ No

If your children have health insurance, send back or bring to the DHS office form 470-2826, *Insurance Questionnaire* (enclosed).

Medical Care

Did any of the children receive medical care in the past three months? ☐ Yes ☐ No

Do you want help with paying medical bills for the past three months for the children?
☐ Yes ☐ No

Child Support Recovery

Do you want to get help from Child Support Recovery for the children named on this form?
☐ Yes ☐ No

Do any of the children named on this form get court-ordered medical support from an absent parent? ☐ Yes ☐ No

If "yes" to either question, give information for each parent who does not live in the home with the children.

Name and Address of Parent Not Living in the Home	Date of Birth of This Parent	Social Security Number of This Parent	Names of This Parent's Children	County Where Court Order is Filed, If Any

For each parent not in the home, please give the following information, if you know:

Name of Parent Not Living in the Home	Name of Employer	Employer's Address	If ever married to this parent, date and place of marriage

If you need more room to give this information, attach another sheet.

Iowa Department of Human Services

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: _____ Your State ID number, if any: _____

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, then stop here.

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you

☐ Someone else in your home ☐ Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement

☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Coverec	Choose One: Add	Drop	Effective Date	Last Name First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement
☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

For office use only:
County # _____
Worker # _____
Date Rec'd _____

Are the children United States citizens?

Everyone who gets Medicaid must provide proof that they are a U.S. citizen. See Comm. 258, *Verifying Citizenship and Identity*, on the back of this page for types of verification DHS can use. Please provide proof that the children named below are U.S. citizens by _____.

DHS may be able to help by doing an Iowa birth records check for any child born in Iowa. To find out more about this call your worker.

Are the children qualified aliens?

Qualified alien children may also get Medicaid. Please provide proof that the children named below are qualified aliens by _____.

To find out more about this call your worker.

Department of Human Services

Verifying Citizenship and Identity

Important Notice!

Federal Medicaid Law Requires Proof of U.S. Citizenship and Identification

U.S. citizens who apply for or get Medicaid will need to show proof of citizenship and identity.
Note: In most cases, if you were born in the United States you are a U.S. citizen.

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.
- Visit the website at http://www.dhs.state.ia.us/.
- Visit the website at www.cdc.gov/nchs/w2w.htm if you need to get a birth certificate from another state.

Examples of How to Prove U.S. Citizenship and Identity

Everyone in your home who gets Medicaid* will need to turn in proof of citizenship and identity. **Proof must be an original document. Do not mail original documents. Bring them to the office.**

- **Column A** proves both citizenship and identity.

If you don't have a document from column A, then you will need to provide documents from column B.

- **Column B** requires a document from both Part 1 and Part 2 to meet the requirement.

Column A	Column B	
Proves both Citizenship & Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport, even if expired • Certification of Naturalization (Form N-550 or N-570) • Certification of Citizenship (Form N-560 or N-561) • Documentation of membership or affiliation issued by a federally recognized Indian Tribe	• Official birth certificate issued by the county or state • Letter from hospital of birth • Other acceptable proof of citizenship	• Drivers license or ID card from the Department of Transportation • School photo ID • School, day care or medical records (for children) • Military ID or dependent card • Other acceptable proof of ID

Important: You must do this for every U.S. citizen in your family who gets Medicaid.

Eligibility will not be affected by race, creed, color, national origin, age, disability, political beliefs, religion, or sex, except where it is required by law.

*People who get SSI, Medicare, or Social Security Disability benefits, people who are in foster care or some subsidized adoptions or guardianships, people who had newborn status from a Medicaid-eligible mother, and people whose citizenship was verified by an automated match with the Social Security Administration do not have to turn in proof.

Comm. 258 (Rev. 3/10)

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