



RESEARCH REPORT

Medicaid Real-Time Eligibility Determinations and Automated Renewals: Lessons for Medi-Cal from Colorado and Washington

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Executive Summary

The Affordable Care Act provided funding to allow states to upgrade their Medicaid and CHIP enrollment and renewal systems. States have implemented electronic application, eligibility determination, and renewal systems in different ways, on different timelines, and with different levels of success. Urban Institute researchers conducted case studies of two states – Colorado and Washington – with high rates of “real-time” Medicaid eligibility determinations and automated Medicaid renewals to identify potential best practices and lessons learned that could be used by policymakers and health coverage advocates in California to help strengthen the state’s Medicaid systems. This paper describes the approaches used by Colorado and Washington to increase administrative efficiencies and reduce barriers for consumers seeking to apply for and renew enrollment in their state Medicaid programs. Lessons learned from this study may be instructive for policymakers in California and other states across the country.

Our main cross-cutting findings are as follows:

- **State real-time eligibility determination and automated renewal systems can work smoothly and efficiently with the Federal Hub while appearing seamless to beneficiaries.** After overcoming early technical challenges, both Colorado’s and Washington’s online application systems communicate almost immediately with the Federal Hub and its connected databases, and with state databases, to conduct real-time eligibility determinations.
- **When real-time eligibility determination systems work well, automated renewals also appear to work well.** Colorado and Washington rely on the same databases for both real-time eligibility determination and automated renewals. The relative infrequency of reported “glitches” affecting the states’ renewal processes suggests that, once a jurisdiction’s real-time eligibility determination system works smoothly, automated renewals do, as well.
- **Real-time eligibility and automated renewal systems are very beneficial for consumers.** All stakeholders in both states said that real-time eligibility systems and automated renewals have been an enormous help to applicants and enrollees, allowing them to obtain coverage more quickly and easily. State Medicaid officials repeatedly emphasized that they did not know how they could have handled the high volume of applications that were received at the rollout of the Medicaid expansion without online real-time eligibility systems.
- **Reliance on self-attestation of income (subject to post-enrollment verification) helps to increase rates of real-time eligibility determinations.** In both Colorado and Washington, policies allowing for the self-attestation of income have enabled higher volumes of real-time eligibility determinations and state audits have found the states’ systems to be operating well and as intended.
- **Online applications, automated renewal systems, and mobile apps work well in Colorado and Washington’s Medicaid programs.** According to officials, smartphones, more than laptops, are what most Medicaid enrollees are familiar with, and both Colorado and Washington have rolled out online Medicaid applications and mobile apps that enable clients to receive and review notices and update information (although neither state has yet to use them to facilitate the completion and/or submission of initial applications for Medicaid coverage).

- ***Navigators and application assisters play a critical role in facilitating enrollment through online application and automated renewal systems.*** A robust navigator/assister system is needed to help clients use the online systems, given the prevalence of complicated household compositions, and beneficiaries with limited English proficiency and low levels of technology literacy.
- ***Paper and in-person applications remain important options for some Medicaid applicants and enrollees.*** Some people still prefer applying in-person or by filling out an application by hand; navigators and consumer advocates reported that this is particularly true for older beneficiaries and residents of some rural communities who have less experience with computers or the internet.
- ***Overseeing large IT systems run by private vendors requires experienced staff and significant planning.*** Skilled, experienced IT staff within government agencies who can oversee large complex IT systems operated by third-party vendors is critical, given the need for careful coordination across IT vendors and public agencies, and the prevalence of unexpected challenges (e.g., “crashes” and cost-overruns).

The implications of our main cross-cutting findings for California’s Medi-Cal program are as follows:

- ***If California wants to increase the rate of real-time eligibility determinations for MAGI applicants in Medi-Cal, it will need to increase the use of its single-point-of-entry online application, CalHEERS, by Medi-Cal applicants or prioritize enabling online real-time eligibility determinations through its county-based systems.*** It appears that a leading reason why California experiences lower real-time eligibility determination rates than Colorado and Washington is because most Medi-Cal applicants do not use CalHEERS, the eligibility determination system developed for the Covered California health insurance marketplace that is able to provide real-time determinations through an online application.
- ***Increased use of CalHEERS should be weighed against the loss of a single application to apply for multiple benefits programs at the county level.*** CalHEERS only processes applications for insurance affordability programs in California, and not for other public benefits programs (e.g., SNAP and TANF) that consumers may want to apply for when they apply for health coverage. It may be possible for California to further align those systems as it builds out the new statewide automated welfare systems (SAWS).
- ***Policymakers may want to conduct a thorough analysis of systems and processes used in all counties to make eligibility determinations and process renewals in Medi-Cal.*** Given the appearance that consumer experiences with Medi-Cal eligibility determinations and renewals may vary considerably depending on an applicant’s county of residence, a 58-county analysis may serve to identify a set of best practices and barriers to enrollment for consumers, as well as to identify potential policy initiatives that could increase access to Medi-Cal coverage in the state.

Colorado and Washington State are prime examples of states that have largely succeeded in transforming their Medicaid eligibility and renewal systems to operate in a highly automated, real-time manner. California, while also making commendable progress, appears to be more challenged by its longstanding reliance on county-based public assistance systems that retain legal responsibility for eligibility determination in Medi-Cal. We hope that the lessons from Colorado and Washington may enable California policymakers, health program administrators, state officials, and other stakeholders to consider new approaches that could permit uninsured individuals and families to more quickly and easily obtain the health insurance they need.

Introduction

The Affordable Care Act (ACA) extended health insurance coverage to millions of previously uninsured Americans by expanding Medicaid to adults with incomes up to 138 percent of the federal poverty level and by offering subsidies to low- and moderate-income people to purchase individual health insurance plans through the ACA's health insurance Marketplaces. To facilitate enrollment and increase administrative efficiencies, the ACA also required states to use a single streamlined application for these programs, and to move from paper applications in Medicaid and the Children's Health Insurance Program (CHIP) to online application systems. The ACA also provided funding to allow states to upgrade their Medicaid and CHIP application, eligibility, and renewal systems.

States have implemented these electronic application, eligibility determination, and renewal systems in different ways, on different timelines, and with different levels of success. Researchers in the Urban Institute's Health Policy Center conducted case studies of two states with high rates of "real-time" Medicaid eligibility determinations and automated Medicaid renewals to identify potential best practices and lessons learned that could be used by policymakers and health coverage advocates in California to help strengthen the state's Medicaid (Medi-Cal) systems. This paper describes the approaches used by Colorado and Washington to increase administrative efficiencies and reduce barriers for consumers seeking to apply for and renew enrollment in their state Medicaid programs. Lessons learned from this study may be instructive for policymakers in California and other states across the country.

Background

The ACA significantly changed the Medicaid program to increase eligibility, streamline enrollment and renewal, and maximize automation and real-time eligibility determinations through electronic verification systems. The ACA also required state Medicaid programs to coordinate with the application, enrollment, and eligibility determination systems of the new ACA Marketplaces. These ACA-driven changes to Medicaid application and eligibility determination systems addressed a patchwork of different requirements, processes, and complexities across the states, which often created barriers to Medicaid enrollment.¹

The ACA expanded Medicaid coverage to nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL) and provided income-based premium tax credits and cost-sharing reductions to qualifying individuals purchasing private health insurance in the ACA Marketplaces. In 2012, the US Supreme Court issued a ruling that effectively made Medicaid expansion voluntary for states.² As of July 2018, 33 states* and the District of Columbia had chosen to adopt the Medicaid expansion.³ Colorado

* Maine adopted the Medicaid expansion through a ballot initiative in November 2017. The initiative requires the submission of a state plan amendment (SPA) within 90 days and expansion implementation within 180 days of the ballot initiative's effective date; however, the Governor failed to meet the SPA submission deadline of April 3, 2018.

and Washington expanded Medicaid and created their own state health insurance exchanges (“Marketplaces”) beginning January 1, 2014.

The ACA aligned Medicaid programs and the new Marketplaces in several ways. It established the same income eligibility standard—modified adjusted gross income, or MAGI—to determine eligibility for premium tax credits and cost-sharing reductions in the ACA Marketplaces, CHIP, and several categories of Medicaid coverage (including the new adult expansion program). The MAGI standard had never been used previously in CHIP or Medicaid. Thus, beginning in 2014, states were required to convert CHIP enrollees and some pre-ACA Medicaid enrollees (primarily children, pregnant women, and caretaker parents) to the MAGI-based eligibility standard and use the new MAGI standard for the adult expansion population. Eligibility standards for certain traditional Medicaid enrollment categories—primarily the aged, blind, and disabled and those needing long-term services and supports—did not change; these Medicaid categories are referred to as “non-MAGI” Medicaid eligibility groups.⁴

The ACA made several other changes to the Medicaid application and eligibility determination systems. Applicants for MAGI programs cannot be required to submit to an in-person interview to determine eligibility.⁵ State Medicaid agencies also must provide assistance to individuals seeking help with enrollment,⁶ accept applications submitted through a website,⁷ and coordinate enrollment with the state’s Marketplace, including requiring electronic interfaces between the programs.⁸ The ACA required state Marketplaces and Medicaid agencies to use a single streamlined application that would enable applicants to apply seamlessly and be transferred electronically to the correct program for enrollment once eligibility criteria were verified. Under the ACA, states were also eligible to receive 90-10 federal matching funds (i.e., the federal government covers 90 percent of the cost, and the state provides 10 percent of the cost) to upgrade or build IT eligibility determination and enrollment systems.

Real-Time Medicaid Eligibility Determinations

Although paper and in-person Medicaid applications must still be accepted, the ACA significantly shifted Medicaid application and eligibility determination systems to electronic and online settings, at least for MAGI programs. State Medicaid agencies also were required to establish timeliness and performance standards for making eligibility determinations.⁹ Regulatory guidance from the Centers for Medicare & Medicaid Services (CMS) clarified that state Medicaid agencies should aim to maximize “real-time” eligibility determinations:

CMS’s Guidance for Exchange and Medicaid Information Technology (IT) Systems Guidance 2.03, issued in May 2011, expands on the CMS expectations for eligibility systems described in the [August 17, 2011 Notice of Proposed Rulemaking] “. . . that will maximize automation and real-time adjudication. . .” through application of liberalized verification policy, streamlined technology, simplified business processes and improved coordination and access to data sources, **toward the end goals of encouraging maximum use of on-line applications and the ability to achieve real-time determinations with ever increasing frequency.** In the March 2012 final rule, we clarified that automated systems can generate Medicaid eligibility determinations, without suspending the case and waiting for an eligibility worker to finalize the determination, provided proper oversight. **In this context, “real-time eligibility determination” means that there is no clearly perceivable delay between the submission of a complete and verifiable application and the response to the applicant regarding the eligibility decision.** The guidance recognizes that not all applications will meet the parameters for a real-time eligibility decision, but continual improvement in efficiency and customer experience must be the goal for all applications.¹⁰ [emphasis added]

To facilitate the real-time verification of eligibility criteria for Medicaid, CHIP, and Marketplace subsidies (collectively referred to as insurance affordability programs, or IAPs), the federal government created a Federal Data Services Hub. The Federal Hub is an electronic portal that enables Marketplaces and state Medicaid programs to automatically verify certain eligibility information provided by applicants, including Social Security numbers, citizenship status, immigration status, and income.¹¹ The Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (among other agencies) all participate in the Federal Hub. The Federal Hub connects to several different databases and data exchanges to verify the information provided by applicants. These include the Social Security Administration's State Verification Exchange System (SVES) to verify Social Security numbers and citizenship, the Beneficiary Earnings Exchange Record System (BEERS) and Beneficiary Earnings Data Exchange (BENDEX) to provide earnings and tax data from the IRS to the states,¹² and the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) interface to verify immigration status.¹³

CMS established eligibility verification standards for online Medicaid application and eligibility determination systems¹⁴ and offered a learning collaborative to help states increase their rates of real-time eligibility determinations.¹⁵ CMS also provided a template for states to describe their MAGI-based verification plans. These eligibility verification standards were designed to increase the efficiency of eligibility determinations while ensuring ongoing program integrity so that only eligible persons would be enrolled.¹⁶

States must follow certain rules when verifying eligibility for Medicaid, but retain some discretion in how they verify self-attested information:¹⁷

- If the Federal Hub has access to data related to certain enrollment criteria (e.g., Social Security number, citizenship or immigration status), states are required to obtain that information from the Federal Hub.
- States are permitted to rely on a Medicaid applicant's self-attestation regarding most eligibility criteria, except citizenship and immigration status, to determine eligibility.
- States must verify income through data checks but are permitted to rely on self-attestation of income to make an initial eligibility determination; if it elects that option, the state Medicaid agency must verify the income after enrollment. States have discretion to verify self-attested income through data available from various sources, including the State Wage Information Collection Agency (SWICA), IRS, SSA, and agencies administering the state's unemployment compensation laws.¹⁸ Even if a state elects to accept applicant self-attestation and conducts post-enrollment income verification, the data-matching conducted at the time of the application may verify self-attested income without the need to conduct any further review.
- Although states may not require individuals to submit supporting documentation unless what they attest to cannot be confirmed electronically or is not "reasonably compatible" with the electronic data, states have flexibility in defining "reasonable compatibility." For example, self-attested income is considered reasonably compatible with information obtained through an electronic data match if both are above, below, or at the applicable income standard.¹⁹ States also have flexibility to define reasonable compatibility for income by establishing a percentage or fixed dollar amount difference

between the applicant's self-attested amount and the income reported through the electronic data matches.²⁰

Automated Medicaid Renewals

The ACA also streamlined the process for Medicaid renewals. Since before the ACA, states have been required to conduct “ex parte” renewals of Medicaid enrollees, meaning state Medicaid agencies must check whether they have enough data to renew enrollment without requiring additional information from beneficiaries. The ACA increased the use of automated systems to conduct those checks. The ACA requires states to conduct renewals no more frequently than every 12 months²¹ and requires state Medicaid agencies to use available information (including third-party databases such as the Federal Hub) to facilitate annual renewals.²² The requirements are as follows:

- If available data show that a given beneficiary remains eligible, the state must inform that person that he/she will be renewed without requiring anything more from the enrollee.
- If the state cannot establish continued eligibility through reference to available data, the state must send the beneficiary a prepopulated form and allow the beneficiary at least 30 days to provide requested information to establish eligibility.
- If the beneficiary does not provide the requested information within the 30 days, there is an additional 90-day grace period for the person to renew without having to submit a new application.²³

States are required to inform beneficiaries that they must report any change in status (such as a significant change in income or a change in household composition) when it occurs, at which point the state must then determine whether the beneficiary remains eligible for Medicaid.

Methodology

To begin this study, we conducted background research on real-time Medicaid eligibility determinations and automated Medicaid renewals, and reviewed the Kaiser Family Foundation's annual survey of state Medicaid agencies²⁴ to identify states that had the highest reported rates of real-time Medicaid eligibility determinations and automated Medicaid renewals. We selected Colorado and Washington (see Table 1) as our two case study states based on their high rates of real-time eligibility determinations and automated renewals, and because, like California, they expanded Medicaid and operate their own health insurance Marketplaces. We selected one state (Colorado) that, like California, has a Medicaid application and enrollment system administered at the county level, and one state (Washington) that administers its application and enrollment system in a centralized manner (i.e., at the state level). We then collected background information on each state's application, enrollment, and renewal systems.

TABLE 1

Health Coverage Characteristics and Real-Time Medicaid Eligibility Determinations and Renewals, 2017

	State-Level Health Coverage Characteristics			Real-Time Medicaid Eligibility Determinations and Renewals	
	Medicaid expansion	Marketplace structure	County-based enrollment	Percent of determinations completed in real time	Percent of renewals that are automated
Colorado	Yes	SBM	Yes	50-75%	≥75%
Washington	Yes	SBM	No	≥75%	≥75%
California	Yes	SBM	Yes	25-50%	50-75%

Source: Brooks, Tricia, Karina Wagnerman, Samantha Artiga, Elizabeth Cornachione, and Petry Ubri. 2017. "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey." Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Note: SBM = state-based Marketplace.

After careful planning with state officials, we conducted two-day site visits to each state, during which we interviewed state Medicaid officials, county officials, navigators, and consumer advocates. In Washington, we also interviewed staff from the state exchange because Washington's exchange operates the online application system for Medicaid. We conducted additional interviews in both states by telephone, prepared transcript-style notes of all interviews, analyzed all the notes, and prepared summaries of each state's system and crosscutting findings. Finally, after completing our analyses of Colorado and Washington's systems, we held two telephone interviews with state Medi-Cal officials responsible for eligibility policy and management in California's Medicaid program. These calls allowed us to learn more about how California's real-time Medicaid eligibility determination and auto-renewal systems work, and to compare and contrast these systems with those in Colorado and Washington.

Below, we provide detailed descriptions of real-time eligibility determination and automated renewal systems in both Colorado and Washington, summarize key crosscutting findings from those two states, and discuss how California's systems work and the potential implications for Medi-Cal of our findings. (Of course, other state Medicaid programs interested in strengthening their enrollment and renewal systems may also find this analysis useful.)

Colorado

The Colorado Department of Health Care Policy and Financing (HCPF) oversees the state's Medicaid and Children's Health Insurance Programs (called Child Health Plus). HCPF works closely with the Colorado Department of Human Services, which administers other public benefits programs. For many years, Colorado combined its application systems for medical, food, and cash assistance, and initially applications were only processed at the county level. Creation of a single statewide online application and eligibility determination system for these programs required significant changes in systems and processes, some of which began before the ACA.

In 2004, Colorado replaced several legacy computer systems for its medical assistance and other public benefits programs and launched a new statewide coordinated application and eligibility determination system: the Colorado Benefits Management System (CBMS).²⁵ CBMS processes applications and conducts eligibility determinations for a variety of Colorado's food, cash, and medical assistance programs. The state continues to add programs to the system. From its initial launch and for several years thereafter,²⁶ CBMS had significant technical and design problems and was the subject of a lawsuit challenging the timeliness and accuracy of its eligibility determinations. Some consumer advocates were concerned about relying on the CBMS system for real-time eligibility determinations under the ACA because of this history, but that experience also motivated new state leadership to make sure the system worked well. Beginning in 2011, a newly created Governor's Office of Information Technology (OIT) took over responsibility for oversight and operation of CBMS. OIT hired a third-party vendor, Deloitte Consulting LLC, to oversee CBMS and to design and construct the system needed as Medicaid eligibility transitioned to MAGI and the state developed real-time eligibility determination and automated renewal capabilities.

In 2011, the Colorado state legislature also voted to create the Colorado Health Benefit Exchange (CHBE), a public-private entity known as "Connect for Health Colorado." Initially, there was tension between CHBE and HCPF over the extent to which the application and eligibility determination systems for Medicaid and the Marketplace would be integrated. CHBE hired its own contractor to develop the IT platform for the Marketplace and initially wanted to build systems that were separate from Colorado Medicaid. But during the second ACA open enrollment period, Marketplace eligibility determinations were incorporated into CBMS and integrated with Medicaid eligibility determinations through a rules engine called the Shared Eligibility System.

Colorado's Real-Time Eligibility Determination System

Colorado's online coordinated application and eligibility determination system has two elements. The first element is Colorado's consumer-facing online application portal, called the Program Eligibility and Application Kit (PEAK), which is built on the Salesforce Platform.²⁷ PEAK, which also launched before the ACA, handles applications for Colorado's food, cash, and medical assistance programs. Today, it also handles applications for Marketplace subsidies, facilitating a streamlined shared eligibility process for both Medicaid and Marketplace premium tax credits. The second element of Colorado's online coordinated application and eligibility determination system, CBMS, processes applications and conducts eligibility determinations for both Medicaid coverage and premium tax credits.

HCPF has a health information office that oversees the Medicaid application and eligibility systems that operate through CBMS and PEAK. HCPF staff work with OIT and the state's IT vendor to develop designs and business rules for those systems, and to test the system after the vendor builds out new designs. One state official explained:

The core of CBMS is really a case management tool. It houses multiple eligibility benefits for the state. And case workers, who are county-based (numbering about 5,000) determine eligibility and manage benefits inside of this CBMS system. It's primarily a JavaScript system. And there's a portal where clients apply—through PEAK—you go online, you apply, and then you can manage your information and get information in this web-based portal. Attached to that, we have a client [mobile application] ...that...interfaces with the system, so [consumers] can update [their

information and...see [their] benefits, find a provider, etc. All these systems interface and talk to each other, but CBMS is the core engine, where the rules engine lives.

Individuals can apply for both MAGI and non-MAGI Medicaid through PEAK, but real-time eligibility determinations are only made for MAGI Medicaid populations. Staff have not developed mechanisms to conduct online real-time verification of some of the eligibility requirements for non-MAGI programs. One HCPF official explained:

We're implementing the electronic asset verification that's required under federal regulations for non-MAGI, but it's not real-time. There's no real-time interaction with these banks and vendors. We haven't implemented that yet, but we're getting close.

For those who apply through PEAK, CBMS makes real-time eligibility determinations for approximately 80 percent of Medicaid applicants.²⁸ Numerous stakeholders report that "real-time" means that online applicants receive eligibility determinations within a few seconds of submitting their applications. State officials emphasized how adoption of the real-time eligibility determination system enabled them to handle the huge increase in Medicaid enrollees following the Medicaid expansion. One official said:

We jumped from a 400,000 caseload to, currently, a 1.2 million caseload. We now cover 25 percent of the state's population on Medicaid. Since we're county-based, we didn't just want to say, 'OK, let's go hire an additional 10,000 workers to make everybody eligible.' We knew we'd have to come up with a system of real-time eligibility and seamlessness for our clients.

Colorado relies on several state and federal databases (available through the Federal Hub) to verify information provided by Medicaid applicants and enable real-time eligibility determinations.²⁹ According to a recent report authored by the Colorado State Auditor,³⁰ most of these electronic verifications occur "within 24 hours of application completion." Specifically, CBMS uses the following databases to conduct verifications:

- the SSA interface and the state's Division of Motor Vehicles (DMV) interface, to **verify identity**;
- the State Verification Exchange System (SVES) at SSA, to verify **Social Security numbers** (which are needed to complete the data matches through the Federal Hub) **and citizenship status**, and as a second-line check when the state department of motor vehicles database shows a discrepancy with the application for age/date of birth;
- the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) and Verify Lawful Presence interfaces, to **verify immigration status**;
- data available through CBMS, to verify **whether applicants provided information to Colorado's Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) program that conflicts with information provided on their Medicaid application**;
- the state Income Eligibility and Verification System (IEVS), which reflects income reported by employers to the Colorado Department of Labor and Employment (CDOLE) and is updated quarterly, **to verify income**; and
- the federal Public Assistance Reporting Information System database, which shows **whether an applicant is receiving public benefits in another state**.

When an application is submitted through PEAK, Colorado accepts each applicant’s self-attestation on several eligibility factors without conducting additional verification: (1) residency, (2) age/date of birth, and (3) household composition. But sometimes inconsistencies appear in CBMS based on DMV or other data that make such reported information “questionable,” and may lead the state to request more information.

The state also accepts applicant self-attestation for income eligibility but conducts post-eligibility determination verification using the IEVS interface. In part to align Colorado’s Medicaid policies with those of its Marketplace, HCPF adopted a “reasonable compatibility” standard for Medicaid income eligibility of 10 percent. That is, if IEVS shows that an applicant has income within 10 percent of what the applicant reported—and that reported amount is within the income eligibility standard—then no additional verification is required, the person is considered income eligible, and no further action is taken. As HCPF explained, reported income is not reasonably compatible with IEVS data in the following situation:

If the employer-reported income through IEVS is more than 10 percent higher than the self-reported income from the individual, AND the person qualifies for Health First Colorado [Medicaid] using the self-reported income, but does not qualify for Health First Colorado using the employer-reported income [for that] individual, then the two income amounts are not reasonably compatible.³¹

According to consumer advocates, Coloradans who are self-employed usually cannot receive real-time eligibility determinations because their income is not routinely reported to CDOLE and thus is not reflected in the IEVS. According to one stakeholder, self-employed individuals are not able to update their income electronically but can submit paper documentation of income to CDOLE regarding their self-employed income. This causes delays in verification, which are compounded because IEVS is only updated quarterly, leading to significant time gaps before such self-reported (and often varying quarterly) income will appear in the IEVS database.

If application information is missing or questionable (e.g., if DMV data are inconsistent with reported age or residency) or does not match data from the applicable electronic verification interface, the applicant is given a “pending” status in CBMS, and HCPF sends the applicant a notice in the form of a letter called a verification checklist requesting additional information needed to determine eligibility for Medicaid.³²

There are several types of information that applicants may be asked to furnish upon receipt of a verification checklist:

- If an applicant’s identity or Social Security number cannot be verified in real time, paper documentation is requested from the applicant and a real-time eligibility determination will not be made until the documentation is verified.
- If an applicant’s citizenship or immigration status cannot be verified in real time, the individual is enrolled in Medicaid or CHIP and given a 90-day “reasonable opportunity period” to provide documentation.
- If other information is considered “questionable” or the reported income is above the eligibility threshold and not reasonably compatible with what is on file in IEVS, the individual is enrolled in

Medicaid or CHIP and given a 10-day reasonable opportunity period to provide additional information/documentation to establish income or the other requested information.

The PEAK system offers the option for enrollees to receive verification checklists and other notices and communications regarding their Medicaid coverage via text message, rather than standard mail. Although the content of such notices is not sent by text message, enrollees receive text messages directing them to view their account in PEAK for the full notice. Notices are generated by CBMS and sent by the state, but county or Medical Assistance (MA) site staff conduct any needed manual review of materials submitted by beneficiaries. Assisters (i.e., county or MA site staff) are also able to access these letters through an enrollee's PEAK account, which allows them to explain the notices to clients. Beneficiaries may provide the requested information directly through PEAK or provide it by mail or in person to their local county office, which conducts the manual review. If a beneficiary fails to provide sufficient documentation in response to these requests for additional documentation and was initially determined eligible, that person is disenrolled from Medicaid subject to notice and an opportunity to respond.

In addition to the above-listed electronic verifications, which are conducted at the time of the application, CBMS automatically checks IEVS on a quarterly basis (after CDOLE updates its employer-reported income database). If a quarterly IEVS check reveals that a beneficiary may have become ineligible for Medicaid during the 12-month enrollment period because of an increase in income, CBMS automatically sends the individual a form called an IEVS letter, which alerts the beneficiary to the finding and, if the beneficiary believes they remain eligible, requests verification of income within 90 days. If the beneficiary fails to provide sufficient documentation in response to an IEVS letter, the person is disenrolled from Medicaid subject to notice and reasonable opportunity to respond.

Individuals may also forgo the online system and apply for Medicaid at county offices or at other MA sites located throughout the state, such as hospitals or federally qualified health centers. MA sites are designated sites certified by HCPF to accept and process applications for Medicaid, along with other state-administered medical assistance programs. Additionally, MA site staff can use CBMS to determine eligibility for CHIP and Medicaid.³³ Some MA sites have kiosks where consumers can apply directly online for Medicaid coverage through PEAK. People may also mail in their Medicaid applications, which are then processed by county staff through CBMS. Real-time eligibility determinations are available through both PEAK (used by applicants and sometimes by staff at community-based assister organizations) and CBMS (used by county staff and staff at certified MA sites). If an applicant does not receive a real-time eligibility determination or must submit further documentation, county enrollment staff and/or MA site staff conduct that review and make the eligibility determination.

As stated above, county workers do not use PEAK when they are working with clients; they have direct access to CBMS, which has a different interface. Challenges often arise when a client attempts to apply—sometimes multiple times—through PEAK or enters information erroneously, and then comes to the county for help. The county worker is not always able to go into CBMS and work around errors that were entered into the client's PEAK application. County staff reported that some community-based assisters still prefer to use paper Medicaid applications, which counties are allowed 45 days to process. One key informant described the concerns among county-based enrollment workers about the initial rollout of the system:

We know that eligibility is extraordinarily difficult. Any little nuance in a case can change the whole fabric of the case. So [the online application system] wasn't well-received at the beginning. Many people said outright [that] they weren't going to use it—they weren't going to have their people participate in PEAK.

People applying for subsidies through Connect for Health Colorado are seamlessly directed to PEAK to fill out their application and get an eligibility determination through CBMS.³⁴ If a person applies for Medicaid directly through PEAK and is determined ineligible for Medicaid, the system will automatically determine whether the person is eligible for premium tax credits and cost-sharing reductions, provide that information to the applicant, and provide a link (a “button”) that will transfer the applicant over to Connect for Health Colorado to shop for a qualified health plan.

Colorado's Automated Renewal System

Colorado began implementing automated renewals in 2012. Until Colorado started using automated renewals, county staff were responsible for manually conducting annual Medicaid redeterminations.

The state's automated renewal process also runs through CBMS, and involves the following steps:

- A redetermination is typically “opened” in CBMS about 75 days before the end of an enrollee's 12-month enrollment period, when the system generates a prepopulated notice, known as an “RRR form”³⁵, with the enrollee's then-current eligibility information (including any data, such as IEVS quarterly income reports, that may have been updated since the 12-month enrollment period began).³⁶
- A renewal packet with the RRR form is sent to the enrollee 60 days before their renewal date, using whichever delivery method (e.g., standard mail, electronic notification) the client elected for notices.
- If the information contained in the prepopulated RRR form indicates that the enrollee is no longer eligible for Medicaid, the notice will list and request the additional information needed from the client to verify eligibility ahead of the 12-month redetermination date.
- If the eligibility information contained in the prepopulated RRR form indicates continued eligibility for Medicaid, the notice states that the enrollee must report if any of the information included in the notice is incorrect or has changed. In the absence of a response from the enrollee, CBMS will automatically renew enrollment on the redetermination date for another 12 months, without requiring any further action from the enrollee.
- If an enrollee replies to a renewal package by providing updated eligibility information *by hand* (i.e., on the form itself), county enrollment workers are responsible for manually inputting that information into the enrollee's file in CBMS. CBMS automatically and electronically routes the application to the appropriate county, based on the enrollee's address on file within CBMS. If an enrollee provides updated eligibility information directly through PEAK, then no further action is required of county enrollment workers to update the enrollee's file in CBMS.

In addition to responding to requests for information, enrollees can update their eligibility information at any time through the PEAK online system, in person at their county office, or by mail.

According to data shared by the state, between 96 and 99 percent of Colorado's Medicaid enrollees who were up for renewal each month from May through September 2017 were processed through the state's automated renewal system. Of those, depending on the month, between 63 percent and 76 percent of enrollees who were up for Medicaid renewal during that five-month period were approved to reenroll in Medicaid for another year, between 23 and 36 percent were denied, and between 1 and 4 percent were "pending" (i.e., subject to further review by eligibility workers).

Significant Changes to Colorado's Medicaid Real-Time Eligibility Determination and Automated Renewal Systems since 2014

During early implementation, many significant changes were made to Colorado's Medicaid real-time eligibility and automated renewal systems to smooth operations and address initial problems. The most significant change to the systems occurred when Marketplace applications and subsidy eligibility determinations were integrated into PEAK and CBMS. In addition, numerous glitches and accuracy issues have been addressed over the years. Consumer advocates agreed that these technical changes have improved the system, but still expressed residual concerns about some remaining accuracy issues.

The system is dynamic; the state reviews and updates the business rules for CBMS regularly and makes quarterly changes in the IT system. HCPF receives feedback and input on the systems through the call centers and counties. There is a county user group and a customer and community partner user group that provide feedback. The state has also set up working groups to discuss how to improve the system. Changes that have been made since 2014 include the following:

- **Improved collaboration between HCPF and CHBE.** Collaboration between HCPF and CHBE improved significantly, and Medicaid and Marketplace application and eligibility determination systems became more fully integrated. Additionally, state Medicaid officials reported that CHBE recently began operating an MA site, which allows state health insurance exchange staff to access CBMS, thereby granting them more flexibility in dealing with clients whose eligibility could not be determined in real-time and whose applications for Marketplace plans are in limbo pending the determination that they are not eligible for Medicaid.
- **Incentives and support to counties to implement the new systems.** HCPF took steps to enable and encourage counties to implement the new, integrated application and eligibility platforms by (1) offering trainings, (2) identifying "front-runner" counties to lead by example, and (3) promoting learning through county-level competition and the provision of performance incentive bonuses.
- **Self-employed and seasonal workers.** Colorado adopted a policy that allows people with variable incomes during the year, such as self-employed or seasonal workers, to annualize their income for the purposes of determining eligibility for Medicaid coverage and Marketplace subsidies. Special questions were added to the application that address variable income. So long as applicants' annualized income is within eligibility limits, they can enroll in Medicaid or receive Marketplace subsidies.

- **Summary page to review before submission.** To ensure that applicants provide accurate information when applying online, since the second open enrollment period, the online PEAK application portal provides a reminder to check the accuracy of the information provided before submission. Applicants can now view a summary page of the information provided. According to consumer advocates, it is still somewhat tedious to edit the application, but this practice has cut down on erroneous submissions and eligibility determinations.
- **Other changes to make PEAK more user-friendly.** HCPF has made the PEAK/Medicaid application more client-centered, user-friendly, and understandable to the average applicant. One consumer advocate gave the following example:

The way they were asking for immigration status: ‘Do you have an eligible immigration status?’ We advocated to change that to: ‘Use this drop-down to tell us what your immigration status is.’

The state also changed the system so that navigators and assisters can log into a client’s PEAK account, see the notices, and explain to the client what is being requested and how to respond. One state Medicaid official observed:

Usability has become key for us. That’s become a major part of what we do, whereas before, it wasn’t. We were implementing eligibility rules. And, now, we always have to consider the consumer-facing part.

- **Mobile application.** HCPF developed a mobile app for PEAK that allows beneficiaries to edit their eligibility information at any time using their smartphone or tablet, and is exploring whether to allow clients to submit initial applications using the mobile app as well. A state Medicaid official said:

We have 100,000 people on our app. Our app needs to become more user-friendly. It’s costly to maintain the apps, but we think it’s the way to go, over time, to drive more client engagement. We love this whole notion of new consumerism.

- **Cloud-based accessibility.** HCPF is creating a new cloud-based system, PEAKPro, that will enable nontechnical eligibility assisters to access the CBMS environment and check their clients’ eligibility and benefits. Officials described PEAKPro as “a different way for community-based organizations to see eligibility without actually having to learn CBMS and [get] into the weeds,” and said that application assisters at the Colorado Department of Corrections have authorization to use PEAKPro.

Addressing Remaining Challenges in Colorado

In July 2016, the Colorado Office of the State Auditor published the results of a performance audit of the PEAK application and eligibility verification system in Medicaid. It found that HCPF “has sufficient internal controls for processing applications submitted through PEAK, determining eligibility, and conducting redeterminations and cost recoveries.”³⁷ But the report concluded that HCPF could improve its oversight on disenrollment of Medicaid recipients when they are determined to have become ineligible for continued Medicaid coverage during the 12-month enrollment period. Specifically, the audit report found that although HCPF’s policies comply with state and federal regulations, it “does not track the timeliness of all disenrollments for Colorado’s Medicaid program.” Although the audit did not find that benefits had been incorrectly extended to ineligible Medicaid recipients (i.e., Medicaid recipients who should have been disenrolled), HCPF agreed to undertake several steps to bolster the program’s

integrity and its ability to track the timeliness of disenrollments, including (1) by developing and implementing “a new CBMS automated report that can be used to monitor and track all Medicaid disenrollments” and (2) by “[working] with stakeholders and county partners to refine guidance regarding the reasonable opportunity period and good faith policy (i.e., extensions) for clients to dispute an ineligibility determination or provide eligibility documentation.”

Despite significant changes and improvements in the system, state officials are continuing to work to address the following challenges:

- Because so many new people enrolled in Medicaid at the beginning of 2014, state and county officials and assisters report being ***inundated at the end of the year when Marketplace open enrollment coincides with the vast majority of Medicaid redeterminations.*** Finding a way to spread out annual renewal dates in Medicaid could help reduce pressure on both eligibility and enrollment workers and the underlying CBMS/PEAK IT systems.
- ***Using regular mail for so many lengthy notices—such as when people have moved—has become a significant and growing expense*** for the state. There is significant interest in continuing to increase reliance on online notices through PEAK for beneficiaries who are comfortable with online notices.
- Some rural counties reportedly have ***IT/broadband challenges*** that undermine county-level efforts to increase clients’ use of PEAK and increase real-time eligibility determinations and automated renewals.
- Although people can apply for Medicaid and cash and food assistance through PEAK, ***the interface between SNAP, TANF, and Medicaid*** continues to be challenging. Although HCPF can obtain some information submitted by Medicaid applicants/beneficiaries who apply for SNAP or TANF enrollment or renewal, the reverse is not true. One consumer advocate believes that some of the problems might stem from CBMS’s inability to provide unique identifiers for each individual. Additionally, federal requirements prevent the use of real-time eligibility determinations for SNAP and TANF, and applicants and enrollees up for renewal in those programs must go to their county workers to submit documentation, conduct interviews, and obtain their eligibility determinations.
- ***The county eligibility determination system creates some challenges.*** In general, “easier” cases result in real-time eligibility determinations and automated renewals, while more complex cases requiring further documentation are routed to county staff. Logjams can result, particularly in counties that lack sufficient resources, training, knowledge of MAGI and CBMS workarounds, or suffer from staff turnover. In addition, several interviewees said that Medicaid beneficiaries tend to move a lot and their files can be transferred to the wrong county. Consumer advocates would like to see some method developed for identifying where in the system an application or renewal is if additional documentation has been requested. There is no indication within PEAK whether documentation has been received, has been assigned to an eligibility worker, has been transferred to another county, or is in a backlog waiting to be assigned.

Washington State

Washington's Medicaid program is called Apple Health. Three agencies participate in Apple Health's eligibility determination and automated renewal systems. Two of them, the Washington Health Care Authority (HCA) and the Department of Social and Health Services (DSHS), are state agencies that existed long before the ACA and its launch. The third, the Washington Health Benefit Exchange (WAHBE), is a public-private partnership, created by the legislature in 2011, to develop and operate Washington's new health insurance Marketplace under the ACA.³⁸ WAHBE operates the **Washington Healthplanfinder**,³⁹ a consumer-facing online system used to apply for both MAGI-based Medicaid and qualified health plans offered in the state Marketplace.

For many years, DSHS was Washington's state Medicaid agency. It housed and handled applications and eligibility determinations for all Medicaid programs and the state's other public assistance programs. DSHS operated, and still operates, Washington Connection,⁴⁰ an online portal through which people submit applications for multiple public benefits programs, including food, cash, and emergency assistance.⁴¹ Until Washington Healthplanfinder was launched, all Medicaid applicants used Washington Connection to apply for benefits and their applications were subject to manual review by DSHS staff for eligibility determinations. Today, in Medicaid, only people who are applying for non-MAGI-based programs use Washington Connection to submit applications; everyone else uses Washington Healthplanfinder to submit online applications. After submission of an application for non-MAGI Medicaid, food, cash, or emergency assistance, DSHS staff review applications, conduct in-person interviews with applicants, review documentation, and, using CBMS, make eligibility determinations for those benefits programs. Although applications can be submitted online, Washington Connection does not perform any real-time eligibility determinations.

Before ACA implementation, HCA became the single state Medicaid agency and was also responsible for overseeing public employee benefits programs. It also operated Washington's Basic Health Plan, a pre-ACA subsidized insurance program designed to help adults who were not eligible for Medicaid obtain health coverage.⁴² HCA oversaw the benefit design, premium structure, and quality standards for the Basic Health Plan and contracted with multiple health plans to provide those benefits.⁴³ With the implementation of the ACA, HCA was given the responsibility for MAGI eligibility determinations. DSHS, however, retained administrative authority over the non-MAGI-based Medicaid programs that serve people age 65 or older, blind people and people with disabilities, and people needing long-term services and supports. As noted above, DSHS also manages applications and determines eligibility for those programs.

DSHS continued to manage and maintain the state's mainframe legacy IT system—the Automated Client Eligibility System (ACES)—which determines eligibility, issues benefits, and shares data between agencies for Medicaid and other public benefits programs.⁴⁴ According to state officials, while implementing the ACA and converting to real time eligibility determinations, DSHS built the rules engine—the Eligibility System (ES)—“on top” of ACES, which connects data from Washington Healthplanfinder to ACES data on Medicaid enrollees and to state wage data. The work developing the Medicaid real-time eligibility determination systems was funded using 90-10 federal matching funds. ACES makes eligibility determinations for MAGI-based Medicaid and shares data on a real-time basis with Washington Healthplanfinder.

Thus, with the implementation of the ACA and the switch to real-time eligibility determinations, three agencies are involved in MAGI-based Medicaid eligibility determinations in Washington. Each agency has its own IT vendor:

- HCA is responsible for developing the policies related to MAGI-based Medicaid eligibility determinations and operates the system for processing Medicaid claims and payments.
- DSHS operates the IT system that reflects HCA's eligibility and enrollment policies.
- WAHBE is responsible for the design, operation, and maintenance of Washington Healthplanfinder.

WAHBE relies on HCA for policy decisions related to the form and content of its online application as it relates to Medicaid, and relies on DSHS (and ACES) to integrate those policy decisions into the ES rules engine and make the initial eligibility determinations. If an applicant does not receive a real-time eligibility determination or must submit further documentation, HCA staff conduct that review and make the eligibility determination. HCA staff also verify income after real-time eligibility determinations. DSHS's role is to provide the behind-the-scenes IT support to make the initial eligibility determinations for Medicaid applicants on Washington Healthplanfinder, while HCA is responsible for any manual reviews and decisions on eligibility.

State officials wanted a single portal for health coverage in Washington that was not limited to lower-income people eligible for Medicaid, but would be seen and branded as a place for individuals to obtain health coverage, whether through private plans or state medical assistance programs. One reason for this policy preference was to meet the needs of families who need different coverage systems, such as CHIP for children and private Marketplace plans for parents. One former Washington official said:

You are talking about the same families. It's not distinct populations. I think many folks felt early on that you have the Exchange population that is talking about higher income people and Medicaid that is talking about lower income people. But that is just not the case. For us, most of the adults that are on the Exchange have kids that are in Medicaid and CHIP.

Washington's Real-Time Eligibility Determination System

As described above, Healthplanfinder is the online portal that collects data from applicants. As applicants fill out information, Healthplanfinder communicates with other IT systems through the Federal Hub to match and obtain information about the applicant. Customers can also use Healthplanfinder to manage their Medicaid coverage. If they elect to receive online notices, letters from the HCA about action steps or automatic renewals will be communicated to them through the online system.

After creating an account in Healthplanfinder, applicants begin to move through a series of questions in the application. The first step is identity proofing, to ensure the system can verify that applicants are who they say they are. Healthplanfinder connects to the Federal Hub (which is linked to the Experian credit reporting system) to verify the applicant's identity. If Experian verifies identity, the applicant can move to the next step in the application. If identity cannot be verified through the Federal Hub, the applicant must provide additional documentation, such as a scanned photo of a driver's license or passport, before continuing with the application. If additional documentation is needed to establish identity, Healthplanfinder displays a notification to the applicant. The applicant is then able to upload a document directly into the Healthplanfinder system. Navigators report that applicants can either upload

a scanned copy of a document or take a photo of the document on a smartphone and upload it to Healthplanfinder. If additional assistance is needed, navigators are available throughout the state, or the applicant can contact the call center. Navigators have portable scanners available to help the applicant make copies of necessary documents. Call center workers, navigators who are certified as “enhanced users,” and HCA staff have authority to manually verify identity. Although there may be a wait, someone is usually available to review identity proofing documents while the applicant is still online in the application. Although identity proofing presented initial challenges, navigators reported that most of those problems have been worked out and that identity proofing rarely prevents someone from completing an application during an online session.

After identity proofing is complete, the applicant moves through a series of eligibility questions in the following order:

- tax filing status and income;
- household composition and relationships among household members;
- citizenship or, if not a citizen, immigration status;
- history of arrest and/or incarceration;
- smoking status;
- pregnancy status;
- existing health insurance coverage; and
- residency.

WAHBE officials reported that, at certain points in the Healthplanfinder application process, the system “pings” the Federal Hub to check and confirm application information in a manner that is not seen by the applicant and generally works immediately and seamlessly. Healthplanfinder exchanges data through the Federal Hub to obtain income information and

- the SVES interface at the Social Security Administration to **verify citizenship status**.
- the SAVE interface at the Department of Homeland Security to **verify immigration status**.

If the data cannot be electronically verified through these data matches, Healthplanfinder notifies the applicant. Immigration and income are the most common areas where applicants may be required to provide additional documentation. Even where more documentation is needed, however, Healthplanfinder permits an applicant to complete and submit the application. In some cases, applicants have immigration documents they can scan, take a picture of, or provide directly to a navigator; these documents are used by HCA staff to send through the Federal Hub verify immigration status. Under federal law, applicants have 90 days to submit documentation relating to immigration status.

After the applicant enters all requested information into Healthplanfinder and hits “submit,” the system immediately sends the application to the ACES/ES rules engine. After submission, the rules engine communicates with various state databases to confirm the information provided by the applicant and to provide an eligibility determination. The process is as follows:

- **Income is verified using data from both the Federal Hub and SWICA.** If the data from both sources show that the applicant has income at or below the eligibility level, then income is automatically verified. If **either** source reports income above the eligibility level, additional documentation is required.
- The rules engine uses reported income and household composition data to **calculate the federal poverty level for each member of the household.**
- Using all the information provided by the applicant and the data provided by state and federal databases, **the ACES/ES rules engine makes an eligibility determination.**

If someone is not eligible for Medicaid, the ACES/ES system determines whether the applicant is eligible for premium tax credits to purchase a qualified health plan. Once the eligibility determination has been made, ACES returns the decision to Healthplanfinder, and Healthplanfinder communicates the determination to the applicant. In general, interviewees reported that the amount of time between an applicant hitting “submit” and an eligibility determination appearing on screen is no more than 10 to 15 seconds. Navigators report being able to complete the entire application process and receive an eligibility determination for a client in 10 to 15 minutes for simple one-person household cases that do not require additional documentation. More complex households may take up to 40–45 minutes.

Washington has elected to rely on applicants’ self-attestation of income and to verify income after the eligibility determination is made. During the application process, Healthplanfinder “pings” the Federal Hub for income data and ACES/ES checks the state income databases, including the state SWICA. If both federal and state data show that the household member is at or under the income eligibility level, no further action is taken. Washington does not use a “reasonable compatibility” standard for income; there is no percentage variation allowed between the self-attested amount and the income amount shown in the electronic databases. If **either** a federal or state database shows income even a dollar above the eligibility threshold, HCA’s staff conduct income verification after the eligibility determination has been made to reconcile the applicant’s self-attestation and the information in the databases. If an inconsistency is found, a case worker must first attempt to resolve it using additional data sources, such as SNAP or TANF eligibility and enrollment information. If the inconsistency is not resolved, HCA then sends a notice to the applicant asking them to submit documentation of his or her income within 15 days.⁴⁵ If the applicant does not respond, coverage is terminated, but the applicant has an additional 30-day reconciliation period during which, if attested income is verified, coverage can be reopened.

If an applicant applies for Apple Health and never responds to requests for verification of application information, **HCA places a flag on the account** so if that person applies again, they will automatically be required to submit information to HCA and will not receive a real-time eligibility determination.

Washington’s Automated Renewal System

At the end of the first year of ACA implementation WAHBE and HCA began to use Healthplanfinder and the ACES system to conduct automated renewals for the MAGI Medicaid population. The process of automated renewal is as follows:

- Approximately 60 days before a client’s renewal date, Healthplanfinder sends a batch of enrollees who are coming up for renewal to the Federal Hub to check all basic eligibility information again; it also runs the batch against state wage data through ACES/ES.

- If discrepancies were found with the Federal Hub during the initial application process, such as with immigration status, and data were manually verified, this information is reflected in the system.
- ACES/ES takes the data received from the Federal Hub and state wage data and determines if the person remains eligible for Apple Health.
- If information in the application can be verified, income is at or below the eligibility level, and the person is still eligible for Medicaid, then Healthplanfinder sends a letter informing the beneficiary that coverage will automatically be renewed. This notice includes the eligibility information that is being relied upon to renew coverage and requires beneficiaries to inform HCA—and provide corrected information—if any of the reported information is inaccurate.
- If any of the key eligibility information provided in the application and through supplemental documentation, such as income, cannot be verified through the electronic databases, HCA sends a prepopulated notice indicating what documentation is needed for coverage to be renewed at the end of the person’s 12-month enrollment period. Clients can log in to their Healthplanfinder account and upload necessary documentation, mail it in, or call the WAHBE call center directly for assistance. Navigators are also available to provide help if someone has not been automatically renewed. If someone is terminated for failing to provide the documentation requested at the time of their renewal, the person has 90 days to reapply without a gap in coverage.

According to the Office of the Washington State Auditor, only about 17 percent of renewals trigger a review by HCA; the remaining enrollees are automatically renewed for another year of coverage.⁴⁶ According to data shared with our research team by HCA, in July 2017, 73 percent of all individuals were automatically renewed, 86 percent of all individuals were renewed timely (meaning another 13 percent provided documentation required for renewal and had their coverage renewed), and the rest did not have their coverage renewed. Of the 13 percent of Medicaid beneficiaries that provided additional documentation, 24 percent provided it within 30 days, 9 percent provided it within 60 days, and 7 percent provided it within 90 days. Those who did not provide documentation within 90 days were renewed during the reconsideration period.

Significant Changes to Washington’s Medicaid Real-Time Eligibility Determination and Automated Renewal Systems since 2014

There were major problems and significant backlogs during Washington’s first open enrollment period in late 2013 and early 2014. Some of these problems related to issues with the Federal Hub, and some related to the programming used in Healthplanfinder, including implementing MAGI eligibility determinations for the first time. Identity proofing and immigration status initially presented the most significant challenges. Numerous issues also arose in the early years because the rules engines in ACES/ES did not accurately incorporate eligibility requirements, or were not able to address complex issues relating to household composition; some of these challenges related to the lack of experience using MAGI to determine eligibility. Glitches occurred during the second open enrollment period as well. All informants agreed, however, that these early challenges were overcome and that Healthplanfinder now

works relatively smoothly with few error messages that cannot be addressed by navigators, call center and HCA staff.

WAHBE and HCA conducted some beta-testing about a month before the beginning of the first open enrollment with navigators and consumer advocates, but the Federal Hub was not available for any advanced testing. Since then, however, **systems have been developed to provide ongoing feedback to improve the system**. HCA, WAHBE and DSHS participate in monthly meetings with county representatives and community stakeholders in King County (the state's largest county) to obtain feedback on how the system is working. In addition, HCA and WAHBE participate in regular meetings with navigators. WAHBE also manages numerous technical advisory committees that provide input on the application, usability, and access issues for the application process. WAHBE also conducts annual surveys of navigators, which are used to make improvements in the system. It also conducts usability testing with various groups before making a change. HCA has working groups that address issues relating to application and enrollment experiences for different populations. HCA and WAHBE publish a detailed user manual with screenshots to help enrollment brokers and assisters navigate Healthplanfinder and address problems that arise as applicants work through the application process.⁴⁷ HCA and WAHBE publish updates to the manual and provide webinars and trainings when changes are made to Healthplanfinder and the manual. Staff at HCA and WAHBE communicate daily and hold several standing meetings to address various operational and policy issues relating to the application and eligibility determination systems.

As the system has worked more smoothly, HCA and WAHBE have implemented several changes to Healthplanfinder, including the following:

- **Allowing people determined eligible for Medicaid to select a managed care plan** during the same online session and automatically enrolling them in a plan if they do not select one. Enrollment in a managed care plan thus occurs within 24 hours of the eligibility determination instead of after HCA sends a letter asking newly enrolled people to select a plan.
- **Giving applicants more information about some of the application questions** as they move through the application. Text box pop-ups appear if a user hovers over a specific question.
- **Placing HCA “community-based specialists” in local communities**, where they develop relationships and work closely with navigators and other assisters to fix or help explain error codes when they occur during the application process.
- **Creating a category of “enhanced users”**—navigators who are specially trained and authorized to work “behind” the consumer-facing portal in Healthplanfinder to manually verify identity and resolve other error codes where the applicant provides documentation.
- **Developing a mobile app for smartphones** that enables account holders to access their Healthplanfinder account and upload pictures of documents required to complete either the eligibility determination or the automatic renewal process. Beginning in July, HBE plans to have the application available in the app.
- **Providing the location of navigators, brokers, and other consumer assisters**, based on language competency and through a Google Maps function on the mobile app.

- **Developing the capacity to track “churn”** and better promote continuity of care by addressing coverage transitions. Such provisions are as follows:
 - » Notifying people 60 days before they will turn 65 and providing a link for them to connect electronically to Washington Connection at DSHS with a prepopulated application to determine whether they may be eligible for one of the non-MAGI categories of Medicaid.
 - » Identifying people who are turning 19 and helping them transition from CHIP to Medicaid (although challenges remain because they must create new accounts and reapply rather than rely on information from the family account already in Healthplanfinder).
 - » Providing navigators with a list of their clients who will soon turn 19 or 65 so that they can assist them in applying for different coverage.
 - » Identifying people who are enrolled in qualified health plans who reach five years as legal permanent residents and therefore might be eligible for Medicaid and sending them a link to submit a Medicaid application.

Addressing Remaining Challenges in Washington

Like officials in Colorado, Washington officials continue to address some ongoing challenges. Although the system is working smoothly, having three different agencies with three different IT vendors presents challenges. This includes coordination challenges for system design and changes, as well as the impact on the entire system if any one of them has an outage. Like Colorado, Washington stakeholders report that assisters and the online systems are inundated during the annual Marketplace open enrollment when so many Medicaid enrollees are also up for renewal.

Although it has made progress reducing a backlog of income eligibility verification cases, the HCA still lacks sufficient resources to clear the remaining backlog. As described by the Office of the Washington State Auditor in a performance audit of HCA’s Medicaid income verification system published in October 2017, enrollment through the ACA’s Medicaid expansion was more than double the state’s initial estimates, but HCA only received funding to meet that initial estimated enrollment and funding for eligibility workers was never increased.⁴⁸ The Auditor recommended that the legislature appropriate more funds for additional eligibility verification workers and for office space to house them. The auditor also recommended that HCA work with the union representing verification workers to establish written performance benchmarks to help manage staffing levels and individual performance to help reduce the backlog and increase efficiency.

HCA and WAHBE have entered into preliminary discussions with stakeholders regarding additional potential changes, including the following:

- **Improving language access** for people who do not speak English or Spanish. The Healthplanfinder website is available in two languages and provides language resources in 20 languages.⁴⁹ Notices and interpretation services are provided in a variety of languages. Consumer advocates are hoping the online application becomes available in more languages as well.
- **Developing a new data exchange** that will enable Healthplanfinder to check SNAP financial (income) information from DSHS/ACES to determine income levels for Medicaid enrollees up for renewal.

- **Modifying the Medicaid managed care plan selection** process so that people who, under federal law, are exempt from being placed in a managed care plan are not required to select a plan at the time they receive their real-time eligibility determination through Healthplanfinder.

Cross-Cutting Findings from Colorado and Washington

Colorado and Washington are similar in significant ways. Both states chose to expand Medicaid, to create their own state-based health insurance exchanges through a public-private quasi-governmental entity, and to develop robust online platforms that could make real-time Medicaid eligibility determinations and support automated Medicaid renewals. Both states leveraged 90-10 federal funding to build their systems, allow applicants to self-attest to some application elements (including income), and conduct post-eligibility-determination verification of income. Both states encountered significant difficulties during the launch of their systems; however, Colorado and Washington both made concerted efforts to overcome these challenges, and now operate successful systems. Both state systems are dynamic and continue to evolve and improve based on experience and the complexities of the diverse Medicaid populations in their states.

At the same time, each state prioritized different policies, had different application and enrollment systems and IT structures before the ACA, and operated in different political contexts when they developed their systems. Some of their implementation strategies also varied, and future goals for their systems differ to some extent.

Although each state is unique and made some different policy decisions in designing their systems, several key crosscutting findings emerged from the case studies:

- **State real-time eligibility determination and automated renewal systems can work smoothly and efficiently with the Federal Hub while appearing seamless to beneficiaries.** Both Colorado and Washington had difficult rollouts of their online application systems with significant error messages and delays, but both have overcome those early technical challenges. Today, both systems communicate almost immediately with the Federal Hub and its connected databases and with state databases to conduct real-time eligibility determinations. In both states, “real-time” is defined as being only a few seconds between submission of an application and receipt of the eligibility determination.
- **When real-time eligibility determination systems work well, automated renewals also appear to work well.** There were few “glitches” in the automated renewal systems reported in either Colorado or Washington. Both states rely on the same databases for both the real-time eligibility determinations and automated renewals. Thus, it appears that once the real-time eligibility determination system works smoothly, automated renewals do, as well.
- **Real-time eligibility and automated renewal systems are very beneficial for consumers.** All stakeholders in both states said that real-time eligibility systems and automated renewals have been an enormous help to applicants and enrollees. State Medicaid officials repeatedly emphasized that they did not

know how they could have handled the high volume of applications that were received at the rollout of the Medicaid expansion without online real-time eligibility systems. Navigators and consumer advocates emphasized how significant automated renewals have been for their clients. One respondent explained that the automated renewal system “allows for continuity of care, access to care, and prevents gaps in coverage.” Navigators reported how clients used to discover that their Medicaid coverage had lapsed when they became sick or needed emergency care, and that this happens much less frequently with automated renewals.

- ***Reliance on self-attestation of income (subject to post-enrollment verification) helps increase the rate of real-time eligibility determinations.*** Both Colorado and Washington rely on consumer self-attestation of income (subject to verification after enrollment) to enable real-time eligibility verification. This policy has helped both states make real-time eligibility determinations and help Medicaid-eligible people obtain needed coverage. State auditors in both states have conducted performance audits of different elements of their state Medicaid eligibility verification systems, found them generally to be operating well and as intended, but identified a small number of areas for improvement which both states’ Medicaid agencies have agreed with.
- ***Online application and automated renewal systems and mobile apps work well in these Medicaid programs.*** Online application and renewal systems work well for most of these states’ MAGI Medicaid enrollees—better than many (including some state officials) had anticipated. According to officials, smartphones, more than laptops, are what most Medicaid enrollees are familiar with, and both Colorado and Washington have rolled out mobile apps that enable clients to receive and review notices and update information (although neither state has yet to use them to facilitate the completion and/or submission of initial applications for Medicaid coverage). One Colorado stakeholder explained:

Consumer technology is evolving so quickly that it’s very hard for government to keep up. Now, everyone has smartphones. No one has landlines. The vast majority of the population being served by Medicaid has smartphones now. [The state] didn’t build CBMS knowing that would happen within 5 or 10 years. So, figuring out what’s a realistic expectation to adapt to the opportunities that the technology, itself offers you. It’s just hard for government to move that fast.

- ***Navigators and application assisters play a critical role in facilitating enrollment through online application and automated renewal systems.*** A robust navigator/assister system is needed to help clients use the online systems. Although most households can complete the application quickly, large households with complicated composition (e.g., different citizenship/immigration status of different members; one person with a disability or needing long-term services and supports, different members of household eligible for different coverage programs) may require multiple income and eligibility determinations. This can cause confusion over which documents are necessary to establish eligibility and may present eligibility issues for non-MAGI programs. Moreover, some Medicaid clients have limited English proficiency and require help from an assister who can translate the application questions for them and answer in English on behalf of their clients. Some Medicaid clients lack the level of “tech literacy” necessary to effectively use electronic application and eligibility portals. In all these circumstances, application assisters can play a critical role in helping individuals and families navigate eligibility systems. Without trained and experienced assisters (whether county, hospital-based, or community-based) these systems would not work for many people.

- **Paper and in-person applications remain an important option for some Medicaid applicants and enrollees.** Some people still prefer applying in person or by filling out an application by hand. Navigators and consumer advocates reported that this is particularly true for older beneficiaries and those, such as residents of some rural communities, who have no experience with computers or the internet. County staff in both states also reported that some people are used to working with their local eligibility workers and still prefer to come in for help from known staff.
- **Overseeing large IT systems run by private vendors requires experienced staff and significant planning.** Skilled, experienced IT staff within government agencies who can oversee large complex IT systems operated by third-party vendors is critical. This is particularly important if multiple systems and vendors must coordinate to build an efficient user-friendly system. It takes time—and funding for the IT contractor—to make fixes to large IT systems and fixes are made in batches. Several officials recommend that, where possible, states should try to align their IT systems through one vendor. Where multiple IT systems and vendors are used, working through different vendors’ responsibilities in advance of a build-out is important. So too are contingency plans if something “crashes.” Additionally, processes will have to be developed to address funding cycles and appropriations in an industry where unexpected challenges and cost overruns often occur. One Washington official discussed the importance of coordinating “software release cadences” by different agencies and vendors, which can vary based on funding and other practical limitations.
- **Building flexibility and workarounds into electronic application and renewal systems is essential.** Because IT changes are expensive to build and implement—especially on a frequent basis—flexibility and workarounds are essential when applicants get “stuck” in the system. Relationships between community-based navigators/assisters and state/county staff responsible for manual review of applications can be particularly important in developing systems for quickly addressing error messages. In Washington, the state has certified “enhanced users”—including some community-based navigators—who have authority to manually verify information and work around error messages in Healthplanfinder. In Colorado, workarounds are more challenging because CBMS can only be accessed by county and Medical Assistance Site staff with authority to directly access the system, and stakeholders reported difficulties in implementing workarounds when error codes are received in PEAK. However, some informants in Colorado reported that county and/or MA site enrollment staff can “pull” individual applications out of the queue. Flexibility and workarounds are key to making these systems work for people.

“Flexibility [is] everything, especially when you are building a system. The logic is complex, and families and households and the scenarios are complex. And you have to get them all to fit into these specific boxes. You’re never going to be able to predict every scenario that will come. You can try as much as you can, but you are going to find a subset of people that your system doesn’t work for. Have an override button. We actually started implementing a lot of override buttons with proper quality controls.” [Washington official]

- **Obtaining ongoing, regular feedback from users of the system initially and after the system is operating is important to identify and address problems and improve the system for enrollees.** Both states developed processes for obtaining feedback from people who use the online systems. Building in feedback from diverse users and consumer advocates enables state officials to fix “glitches” in the system. It also helps identify policy decisions that can improve the system for a particular group of beneficiaries. For example, Healthplanfinder informs Marketplace enrollees in Washington who are about to reach

their five-year mark as legal permanent residents that they may be eligible for Medicaid, and Colorado developed an income-averaging workaround for seasonal and self-employed workers who were unable to obtain real-time eligibility determinations. One county official said:

For the states, I would say they need to really work with agencies [and] organizations that are already doing eligibility to develop a system that works. People have the vision of how they think it works because it is how they want it to work, the people on the outside have another version of how it really impacts the client. So, go to the table looking for partners in the community who have done the work, and work together to develop the system.

- ***Pre-testing new systems before rollout is crucial.*** Beta-testing systems with consumers and experienced assisters is crucial to identifying glitches in new build outs. Some stakeholders—particularly county-level enrollment workers—suggested piloting major system changes before implementing them on a statewide basis, including in places with diverse demographics so various scenarios and challenges can be identified and addressed before a full rollout. One county official said:

It's so important to pilot just about everything before it gets thrown out to thousands of workers. Because having a pilot with 100, compared to a pilot with 5,000, makes a huge difference. Work with a system that has the capacity for the number of workers you're going to have touching the system.

- ***It is important to prepare eligibility staff and assisters who are used to conducting manual review of applications for rollout of a new system or a significant increase in real-time eligibility determinations or automated renewals.*** Moving from manual review of materials to automated eligibility determinations is a significant change for staff, assisters and beneficiaries. The disruption for county workers in particular can be challenging, although even in Washington, Healthplanfinder constituted a dramatic change in what had been a hands-on approach to eligibility and enrollment. Significant changes will need to be made in workflow and business processes. Moreover, outreach, training, learning collaboratives, coaching, and peer support are all important. One Medicaid official said:

Ultimately, the technology isn't the barrier. The barrier is the culture change. If your policy folks can't see past 'This is how we do it, because we've always done it this way,' then you're probably going to be stuck.

- ***Integrating SNAP and TANF application information remains a challenge.*** States may want to decide in advance whether they want to develop data exchanges between Medicaid real-time eligibility determination systems and the state's other public benefits programs. Such integration has been challenging in both Colorado (which still uses a unified application and eligibility determination system) and Washington (which used to have a single point of entry for those programs). A significant challenge is that states do not currently have the authority to develop real-time eligibility determination and automated renewal systems for SNAP and TANF, and eligibility criteria and determination processes differ.
- ***Real-time and automated systems are more challenging to develop for non-MAGI Medicaid populations.*** Neither state uses real-time eligibility determinations for non-MAGI populations (and neither is aware of any other state doing so), but officials in Washington believe that renewals for non-MAGI enrollees could be automated. Moreover, in Colorado, officials are trying to develop systems to verify assets through data exchanges. In both states, officials want to improve the transition for Medicaid

enrollees who are turning 65 and who might be eligible for non-MAGI coverage so that eligibility determinations for non-MAGI coverage can use data already available in the database.

- ***Designing customer-friendly notices that can be understood by enrollees is difficult, but that is not because a state uses automated enrollment and renewal systems.*** Numerous stakeholders in both states raised concerns about how well Medicaid enrollees understand the lengthy notices they receive regarding their applications and renewals. But these concerns exist regardless whether eligibility determination and renewal systems are automated. In both states, notices are longer because Marketplace and Medicaid notices have been combined. Officials in both states expressed concern about the inability of clients to understand and adequately respond to certain Medicaid-related notices. Concerns about the “readability” of these forms are compounded by the requirement that clients adequately respond to requests for some information (e.g., to document income at the time of an application) within 10 days.

TABLE 2

**Key Elements of State Medicaid Real-Time Eligibility Determination & Automated Renewal Systems,
November 2017**

		Colorado	Washington	California
Context for Medicaid RTE Systems	RTE determinations made pre-ACA	No	No	No
	Automated Renewals made pre-ACA	Yes (some)	No	No
	Combined Medicaid & other benefit systems in application & eligibility determination system pre-ACA	Yes	Yes	Yes, only for county systems
	Combined Medicaid & other benefit systems in application & eligibility determination system after RTE implemented in Medicaid	Yes	No	Yes, only for county systems
	RTE for SNAP or TANF	No	No	No
	RTE in Medicaid/CHIP is considered to be within a few seconds of submitting application	Yes	Yes	Yes
Consumer Experience	Mobile app to access and update account/to submit application	Yes/No	Yes/No (but plans to allow mobile applications by July 2018)	No
	Clients can edit their eligibility info online	Yes	Yes	Yes
	Applicants can select Medicaid managed care plan as soon as they receive RTE	Yes	Yes	No
	Enrollment workers can view online copies of notices sent to clients	Yes	Yes	Yes
	Application System allows self-employed and seasonal workers to average annual income	Yes	Yes	Yes
	Summary page for consumers to review accuracy of information before submitting application	Yes	Yes	Yes
Design Elements	Single IT Vendor used to design/manage all elements of RTE system	No	No	Yes
	Frequency of IT design changes (software upgrades) to RTE systems	Quarterly	Bi-Annually	Quarterly
	Beta-testing significant IT changes with navigators/users	Yes	Yes	Yes
	Regular feedback collected from navigators, counties, and other consumer stakeholders	Yes	Yes	Yes
RTE Verification Processes	"Reasonable compatibility" standard for income	10%	None (verification required if any data source shows income exceeds eligibility level)	10%
	Data source used for identity proofing	State Department of Motor Vehicles with Social Security Administration as backup	Federal Hub (Experian)	Federal Hub (Experian)
	Self-attestation of income w/ post- determination verification	Yes	Yes	No, self attestation of income and pre-determination verification before granting final eligibility
	Update income data during 12-month enrollment period	Yes (quarterly)	No	No, only at change in circumstances or renewal
	Connect to Federal Hub & state data before sending renewal notice	No (but income already updated from most recent state data)	Yes	Yes
	Certify some specialized navigators as enhanced users to manually verify data in the online system	County and Medical Assistance Site Workers can work directly in database	Yes	Yes
Coverage Transitions	Auto-pre-population of non-MAGI Medicaid application when enrollee is about to turn 65 & elects to apply for non-MAGI coverage	??	Yes	No, this is a process automated in California
	Notices re: potential Medicaid eligibility and links to Medicaid application sent to legal permanent residents (LPR) enrolled in marketplace plans who are about to reach five years as LPR	No	Yes	No

Note: "Pre-ACA" = Before the first open enrollment period that began October 1, 2013.

Source: State Medicaid officials from CA, CO, & WA (names withheld for confidentiality) in discussion with the authors, 2017-18.

Implications for California's Medi-Cal Eligibility Systems

In this final section, we first provide brief descriptions of how Medi-Cal's real-time eligibility determination and automated renewal systems work, based on two telephone interviews with California officials. Then, we discuss the implications of our in-depth findings from Colorado and Washington for Medi-Cal, and describe potential future actions that state officials and other stakeholders might consider for improving Medi-Cal's performance based on these lessons.

California's Real-Time Eligibility Determination System (CalHEERS)

California, like Colorado, has a county-based eligibility determination and enrollment system for its public benefits programs, including Medicaid, known as Medi-Cal. Before the ACA, California's 58 counties handled all Medi-Cal applications and eligibility determinations. There are three different county eligibility determination systems in California, which are known as the Statewide Automated Welfare System (SAWS). One system supports Los Angeles County, another supports 18 urban counties, and the third supports 39 small and rural counties. SAWS allows applicants to apply for multiple public benefits programs, including Medi-Cal. People can apply for Medi-Cal through their SAWS eligibility determination system online, in person, by phone or fax, or mail an application to their county. None of the three county eligibility determination systems can make real-time Medi-Cal eligibility determinations. Once an application is submitted through SAWS, even if submitted online, the county takes the application, works on it, and makes the eligibility determination within the 45-day federal limit for processing Medicaid applications.

The ACA's requirement that states develop a single streamlined application for both Medicaid and qualified health plans led California to develop an online application system that allows applicants to obtain real-time eligibility determinations for Medi-Cal. That system—the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)—handles applications and eligibility determinations for both Medi-Cal and Covered California, the state's ACA Marketplace. **CalHEERS is similar to the online statewide application and eligibility determination systems developed in Colorado and Washington, and appears to work smoothly.** CalHEERS connects to several databases through the Federal Hub to verify identity (Experian), check immigration status (SAVE at the Department of Homeland Security) and income (IRS). It also verifies income through state databases (the state Income Eligibility and Verification System [IEVS]). These data verifications are conducted in real-time while the applicant is online. CalHEERS also contains the rules engine that make the eligibility determination using MAGI standards. Like officials in Colorado and Washington, Medi-Cal officials define "real-time" as being within 10-15 seconds of submitting the application. **Only people who apply for Medi-Cal online through CalHEERS or over the phone through regional ACA call centers can obtain a real-time eligibility determination.** When people are determined eligible for Medi-Cal through CalHEERS, they can print out a temporary card that will enable them to receive Medi-Cal benefits, immediately. The county will still communicate with the applicant to confirm their final eligibility for Medi-Cal.

California does not make a final eligibility determination for Medi-Cal until income can be verified. California uses a reasonable compatibility standard of 10 percent when verifying income. Self-attested income must be within 10 percent of income verified through other sources. In the case of applications received through CalHEERS, if they are otherwise eligible for Medi-Cal and income data from the Federal Hub or IEVS can be verified and falls within this reasonable compatibility standard, the person can receive a real-time eligibility determination.

Regardless of where or how someone applies (i.e., through CalHEERS or through the county [systems and/or offices]), if an applicant must provide further documentation to verify eligibility, county staff must review that information. According to Medi-Cal officials, each county has established its own business processes for working with its SAWS eligibility determination system. Thus, even if two counties share the same SAWS eligibility determination system, there still may be differences in how those two counties process Medi-Cal applications from an operational perspective. However, they will apply the state required policies and procedures in conducting Medi-Cal eligibility determinations for applicants and ongoing case management of enrolled individuals. The SAWS eligibility determination systems have an interface to communicate with CalHEERS.

Medi-Cal officials we spoke with could not confirm the number or percentage of CalHEERS applicants who receive real-time eligibility determinations. The most recent report on eligibility and enrollment in California's insurance affordability programs—including Medi-Cal, Medi-Cal Access Program (for pregnant women), and Covered California—shows that, for the third quarter of 2016 (i.e., July through September 2016), far more people applied for coverage through the counties (N = 445,733) than applied through CalHEERS (N = 119,500).⁵⁰ Moreover, the number of CalHEERS applications includes those applying for subsidies to purchase qualified health plans through the state's Marketplace. Thus, more than 4 times as many people applied for Medi-Cal through county human services agencies than applied through CalHEERS, at least as of late-2016. Of those that applied through their counties, the largest number of applications were initiated in-person.⁵¹

One Medi-Cal official placed these data in context:

"It is important to note here that Medi-Cal has approximately 13.5 million enrollees and that historically, individuals applied via the counties for Medi-Cal services. Also, many folks applying for health coverage through the counties are also likely applying for other public social services programs such as TANF and SNAP, known as CalWORKS and Cal Fresh, respectively, in California."

California's Automated Renewal System

All three county-based eligibility determination systems run a data verification check by communicating with CalHEERS, which in turn communicates with the Federal Hub. According to Medi-Cal officials, between 40 and 60 percent of people are renewed by way of an "ex parte" automated data verification process. If continued eligibility cannot be verified through automated data exchanges, a county worker manually reviews the file to see if the beneficiary can be renewed "ex parte." Medi-Cal renewals are handled by the counties, even if someone initially applied through CalHEERS. Each county has its own business process for conducting required "ex parte" renewals for Medi-Cal. According to Medi-Cal officials, if a beneficiary cannot be automatically renewed based on information in the system, a bar-coded renewal package requesting additional information is mailed to the beneficiary. Counties have different procedures for handling disenrollment if the beneficiary does not provide the requested

information; some counties automatically disenroll someone if the bar-coded package is not returned within the requisite time, while other counties require a worker to initiate disenrollment.

Medi-Cal does not collect data on how many renewals result from the “ex parte” review and how many require the provision of further documentation by beneficiaries. However, Medi-Cal officials estimate that approximately 40 to 50 percent of beneficiaries up for renewal interact with a county eligibility worker due to not being able to be renewed via the “ex parte” process.

Implications of Our Findings for Medi-Cal

In Table 2, we compare certain key elements of the eligibility determination and renewal systems in Colorado, Washington, and California. Although we did not conduct an extensive analysis of California’s eligibility determination and renewal systems, it appears that CalHEERS—which was developed in partnership with Covered California to handle online applications for both Medi-Cal and qualified health plans—functions very well, and quite similarly to the statewide application and eligibility determination systems in Colorado and Washington.

However, the key difference between California and our two study states is that Medi-Cal has delegated Medi-Cal application processing to the counties, regardless of the pathway initiated by an individual seeking Medi-Cal enrollment or for renewal of existing coverage. Although we did not receive data on the number of real-time eligibility determinations made through CalHEERS, based on the most recent eligibility and enrollment report, the overwhelming majority of Medi-Cal applicants still appear to utilize the county infrastructure to apply for coverage, as they have for decades. A Medi-Cal official explained that there is a possibility that real-time eligibility determinations could be made at the county level because county systems have an interface with CalHEERS and a person may have all the documentation needed at the time of a visit to facilitate a real-time eligibility determination. However, we did not receive any data regarding real-time eligibility determinations made through county applications.

Medi-Cal officials told us that the California legislature has authorized the consolidation of the three different eligibility determination systems used by counties through SAWS into two systems, and eventually into one.

Given this background, we offer several observations for how California might proceed to achieve higher rates of real-time eligibility determination and automated renewal. Specifically:

- ***If California wants to increase the rate of real-time eligibility determinations for MAGI applicants in Medi-Cal, it will need to increase the use of CalHEERS by Medi-Cal applicants or prioritize enabling online real-time eligibility determinations through its county-based systems.*** It appears that a leading reason why California experiences lower real-time eligibility determination rates than Colorado and Washington is because most Medi-Cal applicants do not use CalHEERS, the eligibility determination system that is able to provide real-time determinations through an online application. Medi-Cal officials told us that there have been no outreach and marketing efforts by Medi-Cal to promote the use of CalHEERS—although Covered California’s marketing and outreach does promote the use of CalHEERS, which likely attracts people who need health insurance but who ultimately qualify for Medi-Cal. Currently, it is not clear to what extent the three county-based SAWS systems are able to provide real-time eligibility determinations for Medi-Cal. We do not know whether the anticipated

changes to—and consolidation of—those systems will include efforts to introduce and/or increase the capacity for the system to conduct real-time eligibility determinations, including through online applications. But, if policymakers wish to maintain the status quo regarding the leading role that California’s counties play in conducting eligibility determinations, they may want to promote consumer use of CalHEERS for online Medi-Cal applications and/or prioritize developing county-based systems that can conduct a high rate of real-time eligibility determinations.

- **Stakeholders in Colorado and Washington consistently reported that real-time eligibility determinations reduce barriers for consumers and make it easier to enroll in Medicaid, while creating administrative efficiencies for Medicaid agencies.** Expanded use of real-time eligibility determinations may also increase the rate of automated Medicaid renewals.
- **Increased use of CalHEERS should be weighed against the loss of a single application to apply for multiple benefits programs at the county level.** CalHEERS only processes applications for insurance affordability programs in California, and not for other public benefits programs (e.g., SNAP and TANF) that consumers may want to apply for when they apply for health coverage. CalHEERS refers information to the counties when applicants express interest in those other benefits programs. Despite federal requirements that limit the alignment of these different public benefits systems, Colorado and Washington are pursuing stronger links between their Medicaid and other public benefits programs’ application and eligibility determination systems and it may be possible for California to further align those systems as it builds out the new SAWS.
- **Policymakers may want to conduct a thorough analysis of systems and processes used in all counties to make eligibility determinations and process renewals in Medi-Cal.** It appears that consumer experiences with Medi-Cal eligibility determinations and renewals may vary considerably depending on an applicant’s county of residence. This is not just a function of having three different eligibility determination IT systems, but also reflects the resources, policies, and procedures of diverse counties. A 58-county analysis may serve to identify a set of best practices and barriers to enrollment for consumers, as well as to identify potential policy initiatives that could increase access to Medi-Cal coverage rates in the state.
- **Policymakers may want to require Medi-Cal and the counties to track more information regarding eligibility determinations and renewals in Medi-Cal.** The California Department of Health Care Services (DHCS), in collaboration with Covered California, are already required to make public detailed eligibility and enrollment reports on a quarterly basis, for the purpose of informing the California Health and Human Services Agency, the state Legislature, and the public about the enrollment process for all insurance affordability programs. But the latest available report does not distinguish between applications for Medi-Cal and qualified health plans through CalHEERS or report the number of real-time eligibility determinations made through CalHEERS. Although the reports contain detailed information about the method used to apply through the counties, it does not address how long it takes for applicants to receive eligibility determinations or how many are determined eligible and ineligible after being asked for further documentation. With respect to renewals, although the report shows how many renewals were processed during the quarter (the reporting period), it does not distinguish between “ex parte” automated renewals, “ex parte” manual renewals, and renewals made after beneficiaries provided requested documentation.⁵²

Conclusion

Pushed to innovate by the Affordable Care Act, states have made tremendous strides in creating streamlined application and renewal systems that facilitate access to health insurance coverage for millions of Americans. Through these systems, large percentages of applicants can now apply for and learn of their eligibility (or lack thereof) for coverage in real-time. Increasingly, Medicaid beneficiaries also can be automatically renewed annually for Medicaid when their circumstances have not changed or they otherwise remain eligible. Still, these innovations are being overlaid on a foundation of established and longstanding systems that have served to determine Medicaid eligibility for decades, and—even with the help of the most competent IT contractors—seamlessly merging the old and the new can be a considerable challenge for policymakers and officials.

Colorado and Washington State stand as prime examples of two states that have largely succeeded in transforming their Medicaid eligibility and renewal systems to operate in a highly automated, real-time manner. California, while also making commendable progress, appears to be somewhat more challenged by its longstanding reliance on a county-based public assistance system that retains legal responsibility for eligibility determination in Medi-Cal. We hope that the lessons from Colorado and Washington may enable California policymakers, health program administrators, state officials, and other stakeholders to consider new approaches that could permit uninsured individuals and families to more quickly and easily obtain the health insurance they need.

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- ⁷ 42 CFR § 435.907(a).
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