Integrating Health and Human Services Programs and Reaching Eligible Individuals under the Affordable Care Act: Final Report

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Executive Summary

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) established or expanded health insurance affordability programs (IAPs) that the Congressional Budget Office expects to cover an estimated 29 million people by 2016.[1] The ACA also changed longstanding approaches to determining eligibility for benefits, placing a new emphasis on using electronic data (including data from other need-based programs) to qualify consumers for assistance, whenever possible. Enacted against a background of growing public- and private-sector interest in integrating enrollment, retention, and eligibility determination for health and human services programs, the Affordable Care Act included provisions specifically calling for an expansion of such efforts, using 21st-century information technology (IT) to improve consumer experience and streamline enrollment while lowering administrative costs and protecting program integrity. In view of these developments, the Assistant Secretary for Planning and Evaluation for the U.S. Department of Health and Human Services (ASPE) commissioned the Urban Institute to develop a series of papers exploring integration efforts to date and analyzing available options under the ACA. This final report describes the project's key findings.

Examples of specific integration practices

State and federal agencies as well as private, nonprofit organizations implemented successful integration approaches in three categories:

1. *Basing eligibility determinations and benefits for one program on data from another program.* Examples include Louisiana's use of multiple data sources to renew children's health coverage; Louisiana and South Carolina's implementation of Express Lane Eligibility (ELE) to automatically enroll children into Medicaid and the Children's Health Insurance Program (CHIP) based on their receipt of benefits from the Supplemental Nutrition Assistance Program (SNAP); and Combined Application Project (CAP) demonstrations that furnish SNAP to recipients of Supplemental Security Income (SSI), in some cases dispensing with any need for seniors or people with disabilities to provide new information to SNAP.

2. *Coordinating administration of multiple programs.* Utah's integrated system of case records, rules engine, data-based verification, and benefit payment illustrates the administrative savings that can result from this approach. From 2008 to the system's full implementation in 2010, the caseload capable of being managed by a single worker increased 53 percent.

3. *Coordinating outreach and enrollment* can be done by public agencies, as with Minnesota's use of public employees to manually enroll consumers into Medicaid based on records from previous state programs; or by community agencies, as with efforts by nonprofit groups to help community college students obtain multiple public benefits.

Less successful strategies include efforts that refer consumers to assistance, rather than directly enrolling consumers into benefit programs. For example, one randomized, controlled experiment found that, when tax preparers completed and submitted SNAP forms on clients' behalf, SNAP filing rates were 80 percent higher than with a control group that received only SNAP background information and blank forms. When preparers completed SNAP forms and told families where and how to submit them, no statistically significant differences were observed, compared to the control group.[2]

Key lessons learned from these examples included the following:

- Integration can yield significant gains, but implementation almost always requires considerable effort.

- Basing enrollment on data from other programs can be greatly facilitated by "deemed eligibility" strategies that grant eligibility based on the findings of other programs, despite technical differences between program rules.

- Some data-based enrollment provides consumers with benefits in specific dollar amounts. To achieve high participation levels in such cases may require accepting, for some who would not otherwise receive assistance, at least interim benefit levels lower than would be paid if individuals had applied using standard procedures.

- Significant gains in enrollment and service utilization may result when households can consent to enrollment by accessing benefits—for example, using a Medicaid card to obtain care, or a SNAP card to purchase food—rather than being required to complete even very simple forms.

- Policies that require consumers to take even a small amount of initiative to obtain or retain benefits can dramatically reduce participation levels.

- Federal authorization and guidance can be critically important in enabling state officials to test innovative strategies.

- Integration projects can involve significant up-front investments in IT, but net administrative gains can result after the initial investment is recouped through later, recurring administrative savings.

- Many integration strategies require not just IT systems, but also human beings to play important roles, such as providing hands-on enrollment assistance to individual consumers.

The Affordable Care Act's influence on integration

New opportunities for integration

The ACA's most fundamental new opportunity for integration involves the considerable overlaps between eligibility for IAPs and receipt of human services benefits. This paper's population overlap analyses assume all states implement the expansion in Medicaid eligibility. The reality, of course, is different: as of January 2015, 29 states had implemented the expansion and an additional seven states were considering it. The 29 expansion states, which include high-population states such as California and New York, represent well over half of the U.S. population, so the findings discussed in this section are relevant for the majority of states and the majority of the population.

If all states expand Medicaid, more than 90 percent of recipients of SNAP, Temporary Assistance for Needy Families (TANF), or housing subsidies will qualify for Medicaid, as will more than 80 percent of recipients of child care subsidies and participants in the Low Income Home Energy Assistance Program (LIHEAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[3] Whether they are funded by federal block grants or operate as entitlement programs that serve all eligible applicants, human services programs could potentially use Medicaid records or information obtained through multi-program applications to streamline determination of human services eligibility and benefit amounts, both at initial application and recertification. Uncapped human services programs like SNAP could identify eligible nonparticipants among the many consumers who sign up for IAPs. For example, 80 percent of eligible SNAP nonparticipants will qualify for Medicaid if all states expand eligibility.

Health programs could likewise benefit from eligibility overlaps, particularly with the Earned Income Tax Credit (EITC), SNAP, and LIHEAP. These programs currently serve 40 percent, 39 percent, and 15 percent of newly eligible Medicaid adults, respectively (assuming all states expand eligibility); they also serve 21 percent, 3 percent, and 5 percent of people who will qualify for

subsidized Marketplace coverage. This suggests that targeted enrollment campaigns that use these three human services programs as a starting point for identifying potentially eligible consumers and expediting their enrollment into health coverage could reduce the number of uninsured while lowering the number of individual IAP applications that states must process. The Centers for Medicare and Medicaid Services (CMS) have authorized states to take such steps with SNAP records, using the Secretary's waiver authority under Social Security Act Section 1902(e)(14). A number of states have done so, enrolling hundreds of thousands of people into Medicaid in this way.

Medicaid programs can also use data from human services records to verify eligibility, both at initial application and renewal. Among all people who would qualify for Medicaid if all states expanded eligibility, 49 percent receive SNAP and many receive other benefits, suggesting the broad potential sweep of such strategies.

A second opportunity presented by the ACA involves a uniquely high level of federal funding for IT modernization. Investments in Medicaid eligibility systems can qualify for 90 percent federal funding. An exception to normal cost-allocation rules lets human services programs benefit without sharing in the cost of such investments. Originally slated to end on December 31, 2015, that exception was recently extended for three additional years, through the end of 2018.

Challenges to integration under the ACA

Following are some of the key challenges to integration that emerged during the new law's early years as well as possible strategies for addressing those challenges:

1. States have prioritized implementing core ACA health coverage objectives ahead of integration activities, so many human services programs have not yet taken full advantage of the cost-allocation exception, which can be used to significantly modernize eligibility IT. The exception covers investments to develop or procure (1) business services that help determine both Medicaid and human services eligibility and (2) interfaces between Medicaid and human services systems that allow targeted Medicaid enrollment or streamlined Medicaid eligibility verification. State human services agencies that have done most of the necessary IT modernization work, thus limiting demands on Medicaid staff, have been able to achieve greater integration.

2. Many states have not expanded Medicaid eligibility. This decision limits the number of adults with overlapping eligibility between health and human services programs. Nevertheless, significant eligibility overlaps remain with children, who qualify for Medicaid up to at least 138 percent of the federal poverty level (FPL) in all states. Also, if a state does not expand Medicaid, the lower income-eligibility threshold for adults' Marketplace subsidies drops from 138 to 100 percent FPL. This increases the overlap between Marketplace subsidy eligibility for adults and human services programs that serve near-poor adults, including SNAP, child care subsidies, and LIHEAP.

3. The IT systems for some human services programs do not communicate with their states' more recently modernized health IT systems. Moving from short-term to longer-term approaches to addressing this challenge, states can provide one program's caseworkers with manual "look-up rights" to access data from the other program; create digital interfaces that let incompatible systems share data; or build new, multi-program, modern eligibility systems, using 90 percent federal funding and the cost-allocation exception to lower state development costs.

4. Few states have implemented targeted enrollment strategies to enroll uninsured consumers based on SNAP records. The states that have implemented these strategies required consumers to complete forms. Participation levels could rise and state administrative costs fall if states

instead used "consent through benefit use" strategies, like those employed by Louisiana and South Carolina ELE programs. Such strategies have been shown to remove participation barriers for clients and decrease workload for caseworkers.[4]

5. Several challenges have faced human services programs seeking to expedite eligibility determination with data from Medicaid records, including limits on IAP data sharing. Recently revised CMS regulations as well as longstanding Social Security Act provisions give human services programs access to some (but not all) information from Marketplace and Medicaid program eligibility records, so long as recipient programs take specified steps (e.g., to safeguard data security). While different income definitions apply to Medicaid and human services programs, those differences sometimes can be bridged through "deemed eligibility" strategies and other approaches. Finally, although consumers seeking health coverage may lack the energy to apply for human services programs after completing the process of applying for IAPs and selecting health plans, consumer choice architecture can be structured to realistically address the resulting exhaustion. For example, IAP applicants who appear eligible for SNAP could be informed of that fact and asked if they want someone from their state to contact them later to help them apply for SNAP. Alternatively, before starting the IAP application, consumers could be given the option to complete a multi-program application form, often with the aid of a social services caseworker. As of June 2014, such forms were approved for use in 22 states.

Prospects for future integration under the ACA

The Affordable Care Act continues to offer promising opportunities for integration, which can lessen consumer burden, reduce administrative costs and improve program integrity. Considerable overlaps remain between IAP eligibility and human services program participation, and the recent extension of enhanced funding for health and human services eligibility IT greatly increases the likelihood of significant state investments in integrated systems. However, as a practical matter, meeting the ACA's health coverage goals has limited state and federal capacity to pursue integration strategies.[5] This suggests several possible responses by federal policymakers and others.

First, both federal officials and private foundations could consider supporting integration initiatives, particularly in states that have made some progress toward integration but could use additional resources and guidance to take full advantage of the time-limited cost allocation exception. Documenting best practices in those states that have created effective integration partnerships between their health and human services agencies could provide helpful examples for other states. An important goal of such initiatives would be to develop policies and practices that can be replicated elsewhere when other states are able to move forward.

Second, as state health programs gradually master the ACA's health coverage tasks and develop the capacity to advance integration efforts, federal officials could encourage them to take advantage of integration opportunities. For example, Medicaid regulations require the use of human services case records to verify applicants' eligibility and to facilitate renewals, where states find those records useful. Because of functional limitations stemming from pre-ACA IT systems and the challenges of ACA implementation, some states are not yet fully implementing those regulations. As states develop the ability to add these capabilities to their Medicaid programs, state regulatory compliance is likely to increase, and new approaches to using the fact of benefit receipt to verify eligibility may become viable candidates for exploration.

Finally, further qualitative and quantitative research could explore currently unresolved issues related to integration efforts under the ACA, as detailed in the last section of this report.

Introduction

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) is one of the most significant pieces of domestic legislation enacted in generations. By 2016, the Congressional Budget Office projects that 13 million additional people will join Medicaid and the Children's Health Insurance Program (CHIP), 16 million will receive subsidies through newly created health insurance Marketplaces, and 24 million more people will be insured than without the law.[6][7] More broadly, the ACA set in motion major changes to the nature of eligibility determination for both health and human services programs. The Affordable Care Act required eligibility for health coverage to be based on electronic data matches, whenever possible, including information in the records of human services programs.[8] The U.S. Department of Health and Human Services (HHS) was charged to "develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs," including "electronic matching against existing Federal and State data," "simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility," and "reuse of stored eligibility information."[9]

Along with an enormous volume of other work to implement the law, federal officials took several technology-related steps that were essential to translating these legislative requirements into on-the-ground program modernization. In one notable example, the Centers for Medicare and Medicaid Services (CMS) ruled that investments in information technology (IT) to improve eligibility determination can qualify for the same 90 percent federal matching funding that had previously been reserved to systems that paid provider claims.[10] In a related measure, the Office of Management and Budget (OMB) created an exception to normal cost-allocation rules, thereby relieving human services programs of the need to share the cost of IT upgrades that improve eligibility determination for both health and human services programs.[11] The 90 percent federal funding for Medicaid eligibility investments and the cost-allocation exception were both originally slated to end after December 31, 2015. Recently, however, CMS announced that 90 percent funding for Medicaid eligibility IT would, like funding for automated systems for paying provider claims, be ongoing rather than time-limited; and that the cost-allocation exception would be extended for three years, through December 31, 2018.[12]

These changes have taken place against a background of growing interest in transforming eligibility determination for health and human services programs to reduce consumers' burdens, cut administrative costs, and strengthen public integrity by utilizing 21st-Century IT.[13] This growing interest has been reflected in many diverse efforts, including the Work Support Strategies Project (WSS), supported by the Ford Foundation (among other philanthropies).[14] Other continuing efforts include the Administration for Children and Families' (ACF) National Human Services Interoperability Architecture; the American Public Human Services Association's (APHSA) National Workgroup on Integration; the OMB Partnership Fund for Program Integrity Innovation; and the National Information Exchange Model.

The Affordable Care Act set the stage for transforming health and human services programs through integration and interoperability. Facing a surge in health coverage applications during late 2013 and early 2014, the handful of states that used data from human services programs to qualify consumers for health coverage through targeted enrollment initiatives were able to trim their administrative workloads while covering hundreds of thousands of uninsured.

At the same time, many people who qualify for human services programs, including some who

have not previously received assistance, will seek health coverage. Even in states that do not implement the ACA's Medicaid expansion, the legislation's individual coverage requirement, the effect of creating new Marketplace subsidies, and general publicity around the ACA have generated numerous health coverage applications. Compared to average monthly enrollment during July through September 2013, Medicaid/CHIP participation levels in nonexpanding states had increased by 1.1 million, or slightly more than 5 percent, as of August 2014, according to CMS data.[15]

By connecting to the ACA's new health coverage systems, human services programs can leverage several gains without compromising program integrity. First, consumers seeking health insurance who are also eligible for other programs can be identified and offered the opportunity to enroll in those programs. Second, information obtained through the health programs' verification procedures or through multi-program applications, like those approved for use in 22 states as of June 2014,[16] can simplify the work needed to qualify clients for human services. This may allow capped programs like Temporary Assistance for Needy Families (TANF) and the Low Income Home Energy Assistance Program (LIHEAP) to redirect some limited amount of program funding from administration to services. Third, renewing eligibility based on data matches with health programs could reduce procedural terminations in programs like subsidized child care, where continuity of care is critically important to achieving mission-critical goals.[17] Fourth, human services programs could upgrade their eligibility IT using enhanced federal Medicaid match, rather than human services administrative dollars, as explained earlier. Finally, by reducing the need for applicants and beneficiaries to document facts that are already known to health coverage programs, integration efforts can make it easier for eligible families to enroll and retain assistance—a particularly important step with low-wage, working families, for whom a visit to a social services office can sometimes risk job loss.

Other linkages promise gains to both health and human services programs. These potential gains range from multi-program consumer assistance and enrollment campaigns to shared development and deployment of technology, accomplishing goals together that no single program could achieve alone.

While integration efforts offer great promise, they also face inherent challenges:

- Routine data exchange between programs assumes a level of IT modernization that is much more the exception than the rule in need-based health and human services programs. Most such programs have eligibility IT systems that are decades old.[18] The modernization required by many integration strategies can be costly and time-consuming, even given enhanced Medicaid matching funds and the cost-allocation exception described above.

- Legal requirements that safeguard the privacy of individual information must be addressed and resolved to all parties' satisfaction before agencies can enter into data-sharing agreements.

- Each program's rules for determining eligibility and benefit levels developed independently, responding to unique policy dynamics. As a result, technical differences between program rules abound. This means, for example, that a household whom one program finds to be poor may not be considered poor by a different program. Exchanging data between programs may thus offer limited efficiencies. Such reconfiguration is not always easy, as those rules are sometimes a function of federal statute.

- Effectively integrating the operations of multiple programs can require relationships of trust between the leadership and staff of different agencies. Developing such relationships often takes time. It may also require intervention from higher levels of government to make cooperation a priority at lower levels.

- Most integration strategies require an investment of considerable time and effort from agency management and line staff, which is not always easy to secure, particularly in recent years. Following the Great Recession of 2008-2009, many state agencies are still without their full complement of managerial and front-office staff, leaving them with reduced capacity to take on challenging, innovative projects like integration initiatives.

Despite these and other challenges, a number of state and federal agencies as well as private-sector organizations have successfully pursued integration efforts both before and after the ACA's enactment, motivated by the opportunity for significant gains in administrative efficiency, consumer access to benefits, and program integrity. The Government Accountability Office (GAO) described some of those gains as follows:

> "Improved information systems, sharing of data between programs, and use of new technologies can help programs to better verify eligibility and make the application process more efficient and less error prone. These strategies can improve integrity not only by preventing outright abuse of programs, but also by reducing chances for client or caseworker error or misunderstanding. They can also help programs reach out to populations who may face barriers. One strategy involves sharing verified eligibility information about applicants across programs. Data sharing prevents applicants from having to submit identical verification to multiple programs for which they may be eligible, and it can also speed up the sometimes-lengthy application process. In addition, data sharing allows programs to check the veracity of information they receive from applicants with other databases."[19]

To help state and federal policymakers achieve these benefits from integration and coordination of eligibility determination between health and human services programs following enactment of the ACA, notwithstanding the challenges discussed earlier, the HHS Assistant Secretary for Planning and Evaluation (ASPE or ASPE/HHS) commissioned the Urban Institute to develop a series of papers exploring integration efforts to date and analyzing available options under the ACA.

This overview paper, which is the project's final product, begins by describing our research methodology and previous reports. We then discuss specific examples of integration and coordination, identifying key lessons learned to inform future integration efforts. Next, we explore how the ACA has influenced integration. This includes opportunities presented by the ACA, challenges that have emerged during the new law's early years, and possible approaches to address those challenges. The report concludes by analyzing prospects for future integration efforts under the ACA.

The project's methodology and reports

This research effort began by seeking to identify the most promising potential program pairings for integration and coordination efforts. In analyzing multiple benefit programs, the most important step was to estimate, among consumers who will qualify for Medicaid and Marketplace subsidies, the proportion who participate in a range of specific human services programs. To prepare these estimates, we linked two Urban Institute (Urban) microsimulation

models: the Health Insurance Policy Simulation Model (HIPSM), which has made all necessary imputations and adjustments to estimate health coverage eligibility under the Affordable Care Act; and the Transfer Income Model, version 3 (TRIM3), which is maintained and developed by Urban under primary funding from ASPE, and which has already benchmarked program participation and eligibility estimates for many health and human services programs.

We also analyzed other characteristics of a broad range of health and human services programs, identifying eligibility requirements, verification procedures, and information about the housing and storage of eligibility data. In addition, we developed a typology of integration and coordination strategies, to help policymakers clearly analyze each available option. As a result of these efforts, we identified three human services programs that could be paired most productively with insurance affordability programs (IAPs): SNAP, the Earned Income Tax Credit (EITC), and LIHEAP. The resulting paper, *Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act*,[20] showed the relationship between IAP eligibility and receipt of human services benefits. It included appendices setting out a typology of integration strategies and an analysis of the characteristics of multiple health and human services programs.

Next, we conducted a scan to identify successful examples of integration strategies to illustrate a range of promising approaches. This included a review of the peer-reviewed and "grey" literature. We also contacted multiple experts who were closely following ACA implementation as well as integration efforts throughout the country. Such experts included members of the technical working group (TWG) for the study, leaders of state-serving organizations like APHSA and NASHP, providers of technical assistance to the WSS and Maximizing Enrollment projects, and Urban Institute staff tracking state-level ACA implementation. Once we identified what seemed like the most promising examples of integration efforts, we gathered information about their antecedents, their structure, and their results to date. Whenever possible, we used prior publications to learn about these examples. However, some state or private-sector efforts were sufficiently recent that little or no published literature was available. In such cases, we spoke with key stakeholders by telephone, using semi-structured interview protocols. (Fewer than nine respondents were asked the same questions, per Paperwork Reduction Act restrictions.) Stakeholders were provided draft case studies to review and given an opportunity to comment. This work resulted in *Examples of Promising Practices for Integrating and Coordinating Eligibility, Enrollment and Retention: Human Services and Health Programs Under the Affordable Care Act*.[21]

We also explored the behavioral economics literature to identify patterns of consumer decision-making that could inform the design of effective methods for linking health and human services programs. We chose questions about two specific policy contexts to frame this analysis:

- When consumers apply for health coverage at Marketplaces, how can they be helped to receive human services that they want and for which they qualify?

- When human services program data are used to qualify consumers for Medicaid, how can enrollment into health coverage be structured to minimize consumer burdens, reduce administrative costs, and increase participation levels?

We then identified several behavioral economics areas of research that seemed most pertinent to addressing these questions:

- *Choice overload*. When do additional choices and more complex choices make consumers less likely to make a good decision? More likely to avoid a decision altogether? What can we learn from research about the effect of extra choices on consumer decisions about retirement savings, Medicare, and Medicaid?[22]

- *Mental exhaustion*. What factors make it difficult for consumers to understand the complex costs and benefits associated with insurance, including premiums, deductibles, co-payments, co-insurance, covered services, provider networks, etc.?[23] How can decision architecture strike a balance that provides enough information to allow good decision-making without furnishing so much information that choices become overwhelming?

- *Hassle factors and procrastination*. When does a small inconvenience in completing forms significantly reduce enrollment?[24] What are the effects of strategies to overcome inertia, such as default enrollment, forced choice, or delegated choice?[25] Can consumer assistance overcome inertia and facilitate sound decision-making?[26]

We analyzed research in these areas to identify both potential problems that consumers might face in the above policy contexts as well as possible solutions to those problems. We then conveyed our findings in the report, *Using Behavioral Economics to Inform the Integration of Human Services and Health Programs under the Affordable Care Act*.[27]

Finally, we focused on several specific challenges facing human services programs seeking either (1) to benefit from the cost-allocation exception to modernize eligibility IT or (2) to use IAP data to facilitate eligibility determination for human services benefits. Our goal was to identify concrete, practical strategies for addressing some of the concerns about integration that we heard expressed by human services programs during the initial months of the study. Our analysis was set out in the report, *Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination*.[28]

Examples of specific integration practices

Several noteworthy instances of integration practices, both before and after the ACA's enactment, are described in our report, *Examples of Promising Practices for Integrating and Coordinating Eligibility, Enrollment and Retention: Human Services and Health Programs Under the Affordable Care Act*.[29] They are briefly summarized here.

More successful approaches

We identified successful integration approaches in three major categories.

1. *Basing eligibility determinations and benefits for one program on data from another program*. For example:

   - Louisiana renews children's eligibility for Medicaid and the Children's Health Insurance Program (CHIP) through data from other public agencies, whenever possible. More than three in four renewals (76 percent) are based on data matches with human services programs or other sources of information relevant to eligibility, without any need to contact families for additional information. Most of the remaining children (15 percent) are renewed by telephone, with the rest renewing on-line (2 percent) or through other methods (4 percent). Louisiana vigorously pursued telephonic renewals when data matches did not establish a reasonable certainty of continued eligibility, because officials

had observed that families were much more likely to provide requested information by phone than if they were required to complete and return forms to the state. Nearly all children (95.4 percent) have eligibility continue at renewal, and fewer than 1 percent lose coverage for procedural reasons. Many key elements of Louisiana's renewal policies, such as renewing eligibility based on available data whenever possible, have now been codified in ACA renewal regulations for Medicaid and CHIP.

- Louisiana and South Carolina have implemented Express Lane Eligibility (ELE) to provide children with Medicaid based on the income determinations of human services programs – especially SNAP – notwithstanding differences between SNAP and Medicaid program rules. This "deemed eligibility" strategy was permitted by the federal ELE statute. In these two states, families could consent to their children's Medicaid enrollment simply by accessing fee-for-service Medicaid coverage. In South Carolina, such fee-for-service utilization was quickly followed by mandatory enrollment into managed care, with plans selected by default whenever families did not make a timely choice.[30]

  This initiative has covered more than 20,000 and 92,000 previously uninsured children in Louisiana and South Carolina, respectively. ELE automatically renews numerous children's Medicaid coverage based on their SNAP receipt, eliminating the need for caseworkers to redetermine eligibility manually. Louisiana and South Carolina thus achieve annual net savings of roughly $1 million and $1.6 million, respectively.

  Significant work was required to implement these initiatives, including an investment by the Robert Wood Johnson Foundation to cover necessary initial IT investments in Louisiana. CMS has since made clear that 90 percent federal matching funds are available to finance such investments, and South Carolina funded their IT improvements from that source. ELE-like enrollment initiatives have taken place with adults as well in other states, through targeted Medicaid enrollment under the ACA.

- In many states, Combined Application Project (CAP) demonstrations provide SNAP to recipients of Supplemental Security Income (SSI) based largely or entirely on information these seniors and people with disabilities furnished when they sought SSI.[31] CAP demonstrations have been one of the country's most effective approaches to the longstanding problem of low rates of SNAP participation among the elderly. In 1995, when the first CAP demonstration started in South Carolina, only 31.1 percent of eligible elderly individuals received SNAP, compared to 70.9 percent of eligible individuals as a whole.[32] By FY 2012, the most recent year for which data are available, participation rates rose to 43 percent among the elderly and 83 percent for all SNAP-eligible individuals.[33] The gap in participation levels between elders and others persisted but narrowed over time, highlighting both the deeply rooted nature of this problem as well as the progress that policymakers have achieved through CAP and other measures.

  From 2000 to 2008, CAP states experienced a 48 percent increase in SNAP participation levels among one-person SSI households, at a time when such households' enrollment in other states saw little change.[34] To streamline SNAP enrollment, CAP demonstrations use standardized rather than individualized SNAP benefit amounts, or individually determined benefits reflecting standardized shelter costs, either of which can result in slightly different amounts of aid than if beneficiaries had gone through the full SNAP eligibility assessment process. One way states encourage participation is by mailing SSI

recipients SNAP cards pre-loaded with electronic benefit amounts calculated at the lowest possible level, given potential shelter costs (utilities, rent or mortgage payments, and taxes on the home). To meet cost neutrality requirements, the total benefits paid to all CAP participants must roughly equal the total benefits that they would have received through the regular SNAP program.[35]

CAP participants report high satisfaction levels in consumer surveys. However, despite receiving notice, few CAP participants know they can obtain an individualized eligibility determination, and perhaps additional benefits, by submitting a regular SNAP application or providing additional information about shelter costs.

2. *Coordinating administration of multiple programs*. Through efforts that spanned the better part of a decade, Utah built an integrated system of electronic case records, rules engine, external data matching, on-line applications, and benefit payment that serves multiple health and human services programs. From 2008 to the system's full implementation in 2010, the caseload capable of being managed by a single worker increased 53 percent. From 2009-2010, caseloads rose by 12.3 percent as total operating costs fell by 9.6 percent.[36]

3. *Coordinating outreach and enrollment*. Coordination of outreach and enrollment can involve government agencies or non-governmental organizations:

- In implementing early Medicaid expansion under the Affordable Care Act, Minnesota enrolled eligible consumers through the "low-tech" strategies of (a) making a toll-free number available to hospital emergency rooms and (b) having state and local staff manually convert consumers from a prior state health program to Medicaid. The latter step was cumbersome and administratively costly, but state officials believed that more consumers would receive coverage if public employees did key data entry than if consumers themselves were required to complete the necessary forms. Officials chose not to delay enrollment until new IT systems were ready to handle the necessary work. As a result, the state enrolled 51,583 eligible consumers by the end of March 2011, the expansion's first month. They represented 68 percent of all consumers who received coverage by the end of calendar year 2011.

- Single Stop USA, a nonprofit organization, helps community college students and their families enroll into health and human services programs, while providing financial and legal counseling. At 17 sites in seven states, 18,000 students were assisted in 2012, of whom 29 percent received health and human services benefits averaging $5,400 per student—roughly the maximum Pell Grant for a low-income college student. More than half also received financial or legal counseling. It took considerable effort to incorporate this initiative into existing community college culture, but most school leaders have grown highly supportive, investing much of the funding needed for ongoing program operation.

Less successful approaches

Several strategies that initially appeared promising have not yet achieved major gains. For example, another Single Stop effort involved connecting low-income consumers to health coverage when they filed tax returns at volunteer tax preparation sites. This effort faced serious challenges, including difficulty obtaining the necessary investment of time and staff to provide help with health applications, the unwillingness of many consumers to spend the additional time

needed to apply for health coverage after completing the tax preparation process, and limitations of volunteer tax preparers that forced a cumbersome "hand-off" from tax preparers to others when there were staff available to assist clients with health applications. The ACA strengthens the logical nexus between health coverage and tax preparation, in several ways. Tax preparers will need to reconcile taxpayers' claims of advance premium tax credits (APTC), which are based on projected annual income, with taxpayers' final premium tax credit amounts, which reflect actual annual income shown on year-end tax returns. Also, when taxpayers were uninsured the previous year, their tax returns will either involve tax penalties or claims for exemptions from the ACA's individual coverage requirement. This increased connection between tax preparation and health coverage may provide increased motivation to include IAP applications or adjustments to APTC amounts as part of the tax preparation process. However, the resulting impact on tax preparer involvement remains to be seen.

As another example, referring consumers to programs for which they apparently qualify, rather than actually signing them up for assistance, has often achieved little. One randomized, controlled experiment involved the tax preparation firm H&R Block. When the firm used tax return data and interviews to complete and submit SNAP application forms on behalf of low-income clients, 80 percent more applications were filed than with a control group that received only basic SNAP information and a blank SNAP form. By contrast, no statistically significant effects were observed, compared to the control group, when H&R Block completed SNAP forms, handed them to families, and explained where and how to file them.[37] A comparable H&R Block experiment involving applications for college student aid led to similar results.[38]

Lessons learned

These specific examples teach important lessons for future integration efforts:

- *Integration efforts can yield significant gains, but considerable work is almost always required*, including time for agency leaders to work through policy and practice questions. Breaking down silos between programs to create smoothly operating systems is challenging, particularly when a new approach is first being explored. As frequently noted by Louisiana's Medicaid director, Ruth Kennedy, "Simplification isn't simple; but 'the juice is worth the squeeze.'"[39]

- *Basing enrollment on data from other programs can be greatly facilitated by "deemed eligibility" strategies*, like ELE, that overlook minor differences in technical program rules.

- *When data-based enrollment provides consumers with benefits denominated in specific dollar amounts, achieving high participation levels may require, for those who would otherwise not receive assistance, accepting at least interim benefits lower than would be paid under standard, application procedures.* The CAP experience showed, for example, that pre-loaded SNAP cards helped numerous seniors who would otherwise have gone without assistance. However, many of these seniors could have received additional aid if they had provided proof of higher shelter costs. Although they received notice of the option to obtain additional help, most did not use or even understand those options.

- *Important gains in enrollment and service utilization may result when households can consent to enrollment by using benefits, rather than being required to complete even very simple forms.* With health coverage, consent through card use in Louisiana generated high levels of both enrollment and utilization of health care. During their first 12 months of

coverage, 83 percent of ELE children whose families were mailed Medicaid cards obtained services, compared to 88 percent of children who were enrolled through other methods.[40] When limitations to the state's IT systems forced Louisiana to change its consent method for ELE enrollment and parents had to check a box on the SNAP application form, the average number of children enrolled via ELE as a result of monthly SNAP applications fell by 62 percent.[41] Louisiana and South Carolina, the two ELE states with by far the highest enrollment levels, both allowed families to consent by accessing benefits. Along similar lines, consent to enrollment through use of pre-loaded SNAP cards was part of three out of the four CAP demonstration projects that achieved the highest participation levels. In each state, 70 percent or more of pre-loaded card recipients used them to purchase food.[42]

- *Requiring even a small amount of consumer initiative can dramatically reduce participation levels* in benefit programs. One example is provided by the difference in SNAP participation levels when H&R Block tax preparers actually filed SNAP forms on families' behalf, compared to when they handed families completed forms and told them where to submit these forms. Integration initiatives—indeed, enrollment efforts of all kinds—are likely to increase their effectiveness to the extent that they can eliminate the need for their intended beneficiaries to take action before receiving aid.

- *Federal authorization and guidance can be critically important in empowering state officials to test innovative strategies*. Examples include ELE and CAP, where federal authorization let states move forward and test multiple approaches, some of which proved very effective.

- *Integration projects can involve significant "up-front" IT investments, but the cost of such investments can be more than recouped by later and recurring administrative savings*, as illustrated by efforts in Louisiana, South Carolina, and Utah. However, successful implementation of IT initiatives may require careful testing and incremental "roll out" of each new functionality. Such a step-by-step approach can take considerable time.

- *Manual efforts, not just IT systems, have important roles to play* in integration strategies. Sometimes people must take the place of IT systems that are not yet ready, as when Minnesota used state and local staff to convert consumers from a preexisting state health program to an early Medicaid expansion. Other manual responsibilities are likely to continue, regardless of IT development. One example involves hands-on enrollment assistance, like the help furnished by Single Stop to community college students. Such assistance can be made more effective by modern IT systems, but cannot be replaced by them.

The Affordable Care Act's influence on integration

New opportunities for integration

Data overlaps

The most fundamental new opportunity created by the ACA involves the extensive overlaps between eligibility for IAPs and human service programs, which are the subject of our earlier report in this project, *Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act*.[43] This report estimated the relationship between IAP eligibility and participation in human services programs, broadly defined to include Earned Income Tax Credits (EITC). Under the assumption that all states implement the ACA's Medicaid expansion, the estimated proportions of human services beneficiaries who will qualify for

Medicaid under the ACA are:

- 99 percent for TANF;

- 96 percent for SNAP;

- 91 percent for housing subsidies;

- 86 percent for the child care and development fund (CCDF) and LIHEAP; and

- 81 percent for WIC.[44]

As noted, these estimates assume all states implement the expansion in Medicaid eligibility. The reality, of course, is different: as of January 2015, 29 states have implemented the expansion and an additional seven states are considering it. The 29 expansion states, which include high-population states such as California and New York, represent 58 percent of the U.S. population, so the findings are relevant for the majority of states and the majority of the population.

Block grant programs limited in their ability to enroll new participants could potentially use Medicaid records to streamline eligibility determination, both at initial application and redetermination. If Medicaid has already resolved certain facts about a particular household, accessing those Medicaid findings might reduce the need for a human services program to reexamine those facts, reducing household burdens and lowering state administrative costs.

Moreover, some human services programs, like SNAP and EITC, are not capped and could serve additional eligible individuals, even if the cost exceeded savings associated with streamlined eligibility. Insurance affordability programs could serve as sources of information about such individuals, helping them receive assistance for which they qualify. If all states expand Medicaid eligibility, 88 percent of people who qualify for but do not receive SNAP will be eligible for IAPs, including 80 percent who will qualify for Medicaid or CHIP. In states with multi-program applications, new Medicaid applicants could include many who qualify for SNAP but were not previously enrolled.

State SNAP programs are likely to vary in their degree of interest in such efforts. For example, 13 state-level jurisdictions (including the District of Columbia) already serve 92 percent or more of SNAP-eligible individuals. They are much less likely to see substantial gains in enrollment from a major SNAP enrollment initiative than are the five states where one-third or more of SNAP-eligible individuals do not yet receive benefits.[45]

While data about EITC participation are more limited, IAPs appear to offer considerable potential to reach eligible non-claimants. EITC, which is uncapped, reaches an estimated 75 percent of eligible taxpayers.[46] Among taxpayers *with children* who qualify, 81 percent claim the credit, but only 56 percent of eligible taxpayers *without children* receive it. Altogether, 86 percent of people under age 65 who are eligible for EITC will qualify for health programs if all states expand Medicaid, including 84 percent of EITC-eligible childless adults.

These overlaps also suggest the potential offered by joint outreach and enrollment campaigns. Some uninsured consumers eligible for IAPs could also qualify for but not receive uncapped benefits like SNAP, EITC, and, depending on economic circumstances and program rules, unemployment insurance. In such cases, public agencies and private community groups working on such programs could cooperate in efforts to reach these overlapping populations of eligible consumers and help them enroll in multiple programs at once.

One overall caveat is important, in terms of the gains in enrollment that human services programs could realize from accessing IAP case records. The above estimates involve IAP eligibility, not enrollment. It will take time for the ACA to ramp up enrollment to steady-state levels. The gains described here will thus not be achieved immediately. Moreover, the extent to which human services programs and the individuals they enroll realize the full extent of these potential benefits will depend on the number of states that expand Medicaid and the extent to which Medicaid and other IAPs enroll eligible consumers.

From the more focused perspective of enrolling newly eligible populations into IAPs, the human services programs offering the greatest potential overlap are EITC, SNAP, and LIHEAP. If all states expand Medicaid eligibility, these programs would serve 40 percent, 39 percent, and 15 percent of newly eligible Medicaid adults, respectively;[47] they would also serve 21 percent, 3 percent, and 5 percent of people who will qualify for subsidies to help purchase qualified health plans offered in Marketplaces. This suggests that targeted enrollment campaigns that use these three human services programs as the starting point for identifying potentially eligible consumers and expediting their enrollment into health coverage could help reduce the number of uninsured while reducing the number of individual IAP applications that states must process. CMS has provided guidance about how, using the Secretary's waiver authority under Social Security Act Section 1902(e)(14), states could gain approval to pursue such campaigns using data from SNAP.[48] Several states have employed this strategy to greatly increase Medicaid enrollment.[49]

ACA regulations require Medicaid and CHIP programs to use data from human services records to verify eligibility, both at initial application and renewal, to the extent that states find such information useful.[50] As noted earlier, information showing receipt of human services benefits can establish a high likelihood of Medicaid eligibility. Suggesting the broad potential reach of Medicaid programs' use of such data, among all people who will qualify for Medicaid if all states expand eligibility:

- 49 percent receive SNAP;

- 18 percent receive LIHEAP;

- 17 percent either receive WIC or have a sibling or spouse who receives WIC;

- 9 percent receive housing subsidies;

- 6 percent receive TANF; and

- 3 percent either receive child care subsidies or have a sibling or spouse who receives such subsidies.

IT modernization

As indicated earlier, a longstanding problem facing health and human services programs is outdated eligibility systems. The federal Medicaid statute provides 90 percent federal match for developing Medicaid Management Information Systems (MMIS). However, federal regulations dating from the 1980s limited that 90 percent federal medical assistance percentage (FMAP) payment to systems that paid health care providers' claims.[51]

Soon after the ACA's enactment, CMS promulgated regulations extending the MMIS 90 percent FMAP to cover investments in eligibility systems that met various requirements, including completion by December 31, 2015. CMS made clear, in its regulatory preamble, that

developments since the 1980s, culminating in the ACA's requirements for streamlined eligibility determination and the integrated operation of Medicaid and health insurance Marketplaces, required system modernization, which in turn required extending MMIS 90 percent match to Medicaid eligibility investments.[52]

OMB, recognizing that common eligibility systems serve Medicaid and human services programs in most states, created an exception to ordinary cost-allocation rules. This exception let human services programs benefit from IT investments that were essential to the Medicaid program's modernization without requiring human services agencies to share the development costs. Like 90 percent FMAP for Medicaid eligibility IT, the cost-allocation exception was slated to end after December 31, 2015.

These administrative policies offer health and human services programs a unique opportunity to modernize their eligibility IT systems with the aid of more federal resources than were available in the past. Recently, the federal government changed its time frame in two important ways. First, Medicaid programs can access 90 percent matching funds for necessary IT investments in eligibility systems without a defined end date. In this way, IT investments in Medicaid eligibility systems are now treated like investments in Medicaid systems for paying provider claims. Second, the cost-allocation exception will be available for expenditures made through the end of 2018, rather than 2015. These important revisions are likely to substantially increase the feasibility of state investments in IT systems needed for effective integration of health and human services eligibility determination. Effective IT procurement can require considerable time, given such factors as state competitive procurement requirements and the advantages of multiple testing cycles before deployment.

Challenges to integration under the ACA and possible strategies to address them

ACA priorities and the limits of administrative capacity

As noted, states have prioritized implementing core ACA health coverage goals ahead of integration activities. One result of this is that federal and state health agencies have devoted little administrative capacity to working on integration with human services programs. In part, this has resulted from the ACA's policy context, with features that include the following:

- The ACA calls upon health insurance Marketplaces in 50 states and the District of Columbia to play a central role in program administration. These institutions did not exist when the legislation was signed into law.

- The ACA makes some of the most significant changes to how Medicaid and CHIP determine eligibility since the Medicaid program's creation in the mid-1960s. These changes apply whether or not states expand Medicaid eligibility. Key components include:

  o A shift from traditional public benefit program definitions of household and countable income to federal income tax definitions. The latter involve modified adjusted gross income (MAGI), which Medicaid programs are required to use for most groups other than people with disabilities and seniors. MAGI applies to CHIP as well.

  o A shift from traditional methods of benefit administration that wait for consumers to provide documentation to a more proactive approach that requires Medicaid programs to affirmatively seek out electronic data that qualifies consumers for assistance. For

example, before asking applicants for verification of eligibility, states must now see whether reliable, third-party data are reasonably consistent with applicants' sworn attestations; if so, eligibility is confirmed, and applicants may not be asked to provide documentation. Along similar lines, if beneficiaries' continued eligibility is shown by reliable sources of data, states must renew coverage administratively, without asking beneficiaries for information proving continued eligibility.

- The ACA requires all IAPs to establish seamless systems of "no-wrong-door" enrollment. Section 1413 of the law required the establishment of infrastructure that lets consumers apply on-line, by phone, by mail, or in person by submitting a single, streamlined application to any IAP. Regardless of where or how an application is submitted, IAPs must cooperate behind the scenes to route each applicant to the appropriate program, without asking for additional or duplicative information beyond that on the original application itself.

- State health agencies expected to oversee these major changes have been depleted of management resources in much of the country. During the Great Recession of 2008-2009, most states faced serious budget challenges. One common result was to thin the ranks of experienced managers, making it more difficult to implement the ACA.

- At the same time, federal implementation resources have been limited. HHS has been subject to sequestration and other budget constraints.

- Private vendors tasked with implementing major IT builds are also stretched thin. All state Medicaid programs are taking advantage of 90 percent FMAP to implement major modernization projects, placing great demands on the vendor community. At the same time, 17 states originally decided to operate Marketplaces, each building its own IT infrastructure, as the federal government worked to develop its Marketplace IT. Simultaneously, some human services programs have sought to modernize their own eligibility systems, taking advantage of the time-limited exception to the cost-allocation rules described above. A finite group of vendors has been called upon to carry out all of these initiatives, raising questions about the availability of sufficient expert capacity.

Federal guidance also has emphasized to states the importance of focusing on the ACA's core health coverage milestones. A joint communication from CMS, the Food and Nutrition Service of the U.S. Department of Agriculture (which administers SNAP), and ACF (which oversees TANF, LIHEAP, CCDF, most other human services block grant programs, and child support enforcement), informed state health and human services programs in January 2012 that the need for IAP eligibility systems to be functional in time for the ACA's first open enrollment period was a higher priority than the integration of health and human services programs:

"January 1, 2014 marks the expansion of health insurance coverage through new Affordable Insurance Exchanges … and Medicaid. We encourage States to consider the benefits of interoperable systems [that serve both health and human services programs] and how system development can be staged to ensure that the Affordable Care Act timeframes are met. Many States will make long-needed investments in Medicaid, CHIP and Exchange eligibility systems, and these systems need to be operational and fully tested no later than the summer of 2013. While we encourage States to take into account the needs and requirements of human services programs in developing these systems, *any human services system requirement that would delay meeting the [health] deadline will not be permitted*."

"States pursuing an integrated eligibility system strategy should consider mechanisms for phasing their IT development, such that the additional functionality needed to determine eligibility for human services programs can be added after the health components are operational. It is not required that a State implement a shared eligibility system through a phased approach, but it is an allowable approach and may enable States to implement the health components of an enterprise system in accordance with the Affordable Care Act requirements."[53] (Emphasis added)

Possible mitigation. To address the problem that many state health agencies lack the administrative capacity to undertake significant integration initiatives in the near term, several approaches are possible. One focuses on testing promising integration strategies with the small number of states that have achieved above-average progress in mastering the core challenges of ACA implementation. A second approach would gradually ratchet up the level of integration that federal agencies expect of states in general. These approaches are discussed in more detail below, in the final section of this report.

The cost-allocation exception

As noted earlier, the combination of 90 percent FMAP for Medicaid eligibility investments and a cost-allocation exception that allows human services programs to benefit from such investments represents a unique opportunity to modernize eligibility IT for health and human services programs at reduced cost to states and localities. All Medicaid programs have taken advantage of this opportunity.[54] Many human services agencies have not yet done so fully, given the requirement to prioritize accomplishment of the ACA's core health coverage functionalities.

The cost-allocation exception has limits, which are explored in this project's report, *Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination*.[55] The exception covers only investments that involve either—

- the development or procurement of a business service that serves both Medicaid and human services programs; or

- the construction of an interface between Medicaid and a human services program that helps the Medicaid program (1) verify eligibility or (2) "fast track" Medicaid enrollment of uninsured individuals, based on information in their human services case files. This step can also include development of the functionality needed for the interface to obtain necessary information from human services records, functionality that can help the human services program in other ways as well.

Possible mitigation. Now that the cost-allocation exception is available through the end of 2018 and Medicaid programs can access 90 percent federal match for eligibility system IT investments without a defined time limit, significant use of this exception to integrate eligibility IT across health and human services programs now appears much more realistic in future years, after the near-term ACA implementation requirements abate.

Until then, human services programs may increase their capacity to successfully tap into these resources by taking an approach that minimizes time demands on Medicaid staff, given the competing demands of ACA implementation. As one possible strategy, the human services agency could volunteer to carry out most of the work needed to develop or procure a new service or interface that promises to serve both health and human services programs. Thus far, the states

that have used this exception frequently employed this strategy, with human services staff carrying out much of the work required to modernize shared eligibility systems.[56]

This opportunity is available in all states. Whether or not a state expands Medicaid eligibility, the ACA requires it to use data matches with reliable sources, whenever possible, to determine eligibility.

Medicaid expansion decisions

In June 2012, the U.S. Supreme Court rejected a constitutional challenge to the ACA's individual coverage requirement but struck down the law's mandatory expansion of Medicaid coverage to adults up to 138 percent of the federal poverty level (FPL).[57] The Court ruled that each state could choose whether or not to implement that expansion. As of January 2015, 29 states (including the District of Columbia) are moving forward with the expansion, 15 states are not, and seven states are still debating the issue.[58] In states not expanding Medicaid, there are fewer people who are both IAP-eligible and participating in human services programs than there are in states that are expanding eligibility.

Possible mitigation. Even nonexpanding states offer major overlaps between health and human services programs and important opportunities for integration:

- In all states, considerable overlaps apply to children, whose health coverage was not affected by the Supreme Court decision. Medicaid must cover children through age 18 up to at least 138 percent FPL. Above that level, children not receiving employer coverage often qualify for either CHIP or subsidies to enroll in qualified health plans (QHPs) in the Marketplace.

- In states that do not expand Medicaid, the lower income bound for QHP subsidies falls from 138 to 100 percent FPL. This increases the potential overlap between QHP subsidies and human services programs that serve some consumers with incomes slightly above poverty, such as LIHEAP, child care subsidies, WIC, SNAP, and EITC.

- Nonexpanding states and expanding states have equal access to 90 percent FMAP for Medicaid IT improvements and the cost-allocation exception.

Limited compatibility between health and human services IT systems

A Medicaid eligibility IT system may be unable to communicate with its counterpart in a human services program for many reasons, including incompatible software developed by different vendors, more rapid modernization of Medicaid than human services eligibility IT, and the absence of data-sharing links.[59] Regardless of the cause, limited compatibility between program IT systems can present a challenge to efficiently integrating multiple programs.

Possible mitigation. An interim, short-term approach to overcoming this barrier can involve the use of manual workarounds. For example, one program can gain "look-up rights" to access information in another program's records. When Alabama was first implementing ELE, it took this approach to accessing SNAP and TANF records, and granted children Medicaid eligibility. This initial step did not provide the same level of efficiency gains as the state's later implementation of automated data-matching between human services programs and Medicaid, but the initial, manual approach let the state achieve some administrative savings.[60]

A medium-term solution involves the use of the cost-allocation exception to fund the development of interfaces that close the gap between eligibility systems. Such interfaces could

permit an older human services system and a more modern Medicaid system to exchange data efficiently. As one incidental benefit, human services programs might be able to use that same interface to exchange data with other modernized IT systems. The additional cost of adjusting the human services interface to work with other, non-Medicaid systems would not be covered by the cost-allocation exception, but it would likely be much lower than the expense of building a new interface from scratch.

A longer-term and more comprehensive solution involves the development of modernized, fully integrated, multi-program eligibility systems like Utah's, described earlier. Such systems take significant time and effort to develop, but the state's cost should be mitigated by the above-described 90 percent FMAP and cost-allocation exception.

Challenges unique to Medicaid

Targeted enrollment strategies that used SNAP data to provide consumers with Medicaid, described above, achieved significant results in several states,[61] but most states have not implemented these strategies.[62]

Another limitation of targeted enrollment strategies, as applied, is that they have all been implemented to require the completion of forms before uninsured consumers receive Medicaid. As noted earlier in connection with ELE, participation levels can be much higher when enrollment does not require such steps. This finding is consistent with a large body of behavioral economics research finding that requiring consumers to take apparently modest procedural steps to obtain public benefits or to enroll in private retirement savings accounts can cause a steep drop in take-up. This literature is explored in this project's paper, *Using Behavioral Economics to Inform the Integration of Human Services and Health Programs under the Affordable Care Act*.[63]

Possible mitigation. The latter paper also explores how participation levels under targeted enrollment efforts could be increased by eliminating the need for consumers to complete paperwork. State Medicaid programs have accomplished this in the past by: (a) asking eligible consumers to select a managed care plan within a specified period and, if they failed to choose, enrolling them into a plan automatically assigned by the state; and (b) sending eligible consumers Medicaid cards which, when used to seek fee-for-service care, triggered mandatory managed care enrollment, with a plan selected by default if consumers did not make a choice. The latter approach, used by South Carolina's ELE program (as described earlier), is more likely to meet the "Medicaid application" requirement that governs targeted enrollment waivers, but the former could be modified to meet that requirement.[64]

Given other pressing priorities, states have not yet enacted business rules that use human services programs' case records to verify applicants' attestations of financial eligibility for Medicaid or to trigger administrative renewal. In the transition of pre-ACA beneficiaries to MAGI-based eligibility, CMS has indicated to state officials that SNAP records could be used to confirm such eligibility,[65] but other human services program records could presumably do so as well.

Challenges unique to human services programs

Legal access to health program eligibility records

Human services programs only recently gained the ability to use health records to facilitate eligibility determination. In March 2014, CMS clarified that such programs could gain access to

most information provided by the federal data services hub (Hub) that furnishes verification to health insurance Marketplaces. That hub provides information from federal data sources, such as the Internal Revenue Service (IRS), Social Security Administration (SSA), and Department of Homeland Security (DHS), as well as certain private information sources contracting with CMS, such as "The Work Number," a service furnished by Equifax that provides near-real-time access to payroll records for employees of many large companies.

Possible mitigation. The March 2014 final federal regulations now permit human services programs to access most information in the possession of Marketplaces (except for tax records), as well as other information in the possession of Marketplaces. To obtain this information, human services programs must:

- obtain consent from the affected individuals;

- show that the Marketplace would benefit from information exchange; and

- ensure that the information will remain protected by confidentiality and data security safeguards no less stringent than those that apply within the Marketplace.

In addition, Social Security Act §1137 permits TANF, SNAP, and certain other human services programs to access information directly from Medicaid programs, without going through the Marketplace. These issues are explored in detail in our paper, *Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination,* referenced above.

However, the Hub has other limitations on data access. The data sources themselves restrict permitted uses of the information they provide. As of this writing, such information can be used only to verify IAP eligibility. In addition, some data in the possession of the Hub's federal source agencies that is essential to verify eligibility for human services programs as well as non-MAGI-based Medicaid is not available through the Hub. These limitations reflect the Hub's primary purpose – namely to verify eligibility for MAGI-based IAPs.

Despite these limitations, many human services programs can access the Hub's federal source agencies via pre-ACA data matching systems that directly link states with SSA, DHS, the IRS and other federal agencies. Non-governmental information sources, such as The Work Number, often contract directly with human services programs as well.

Moreover, human services programs can access information from exchanges and Medicaid systems that does not come from the Hub, so long as applicable statutory and regulatory requirements are satisfied. This includes information provided by IAP applicants and beneficiaries themselves. It also includes verification that IAPs received from sources outside the Hub, such as quarterly wage records maintained by state workforce agencies.

Different eligibility rules in health and human services programs

Our earlier paper, *Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination,* also addressed a second challenge facing human services programs. Household definitions and other detailed eligibility rules differ between human services programs and Medicaid, which now uses MAGI for most beneficiaries, as explained earlier. Also, procedures used to verify eligibility now vary greatly between MAGI-based Medicaid and human services programs.

Possible mitigation. Despite these differences, eligibility information from Medicaid records could still prove useful to human services programs, in several ways:

- Medicaid records could confirm that particular individuals meet nonfinancial eligibility requirements for human services benefits, such as citizenship or status as a qualified alien.

- A human services program could "deem" someone eligible based on Medicaid's finding of financial eligibility, notwithstanding technical differences between program eligibility rules. This is an easier prospect for block-grant programs, where states have considerable flexibility in defining eligibility rules and procedures, than for SNAP, where federal statutes and regulations define many applicable parameters. For SNAP, it may be worth exploring the possibility of federal waivers to deem eligibility or benefit amounts based on Medicaid findings.

- If it uses block grant funding that provides considerable state-level flexibility in setting eligibility rules, the human services program could change those rules so that, for some or all households, Medicaid and the human services program define income in the same way. A Medicaid income determination could then establish eligibility and benefit levels for the human services program.

- Medicaid's records could be used to pre-populate an application form for human services benefits—e.g., with an address or social security number—or provide the human services program with verification obtained by the health program. The latter could either confirm eligibility for human services or raise a "red flag" suggesting a need for further investigation.

Fitting human services programs into an already demanding IAP application process

A third set of challenges facing human services programs involves giving new health coverage enrollees who are not receiving human services benefits an opportunity to apply for SNAP (or other human services programs with the capacity to accept new participants). If consumers can apply for health coverage and SNAP at the same time,[66] the effort required to apply for IAPs and select a health plan may prove so overwhelming that submitting a SNAP application could be beyond what many consumers have the remaining energy to carry out. This risk is suggested by the findings of behavioral research described in our paper, *Using Behavioral Economics to Inform the Integration of Human Services and Health Programs under the Affordable Care Act,* referenced above.

Possible mitigation. The latter paper also explored several possible strategies for addressing those challenges, along with two related issues: the limited administrative capacity of most health agencies to develop systems to facilitate the enrollment of health applicants into human services programs; and the desire for Marketplaces to attract and serve consumers of all income levels.

As one possible strategy, IAP applicants who are identified as likely eligible for SNAP could be informed, after completing the IAP enrollment and plan selection process, that they may qualify for help purchasing food. If they would like someone from the state's SNAP agency to contact them, they could be asked for their preferred contact information (cell phone, text, email, land line, etc.), and the best times to contact them. Someone from the state's SNAP agency would then follow up to help them apply for SNAP.

This strategy limits the cognitive demands placed on a consumer who has just finished a health

application; the consumer needs to do nothing more than provide contact information and consent to the state food agency's later follow-up. It limits stigma because the only health applicants to whom SNAP is raised as a possibility are those poor enough to qualify. The administrative demands on the health agency are minimal. Programmers must do enough coding to ask one question of the applicant and export contact information to the SNAP agency. (However, unless the health agency is willing to provide for additional information exchange with the SNAP agency, the consumer will need to furnish the SNAP agency with some of the same information the consumer provided as part of the IAP application.)

A second possible strategy would give the consumer a choice before beginning the enrollment process. The consumer would be asked to apply either for health coverage alone or for both health programs and human services programs, including SNAP. As of June 2014, 22 states had multi-program applications approved for use.[67] Eligible consumers who complete a multi-program application would receive SNAP, avoiding the risk of "falling between the cracks" and missing out on SNAP because of failing to receive sufficient follow-up. On the other hand, this approach requires time and effort from state and federal health officials in developing, reviewing, and approving a multi-program application. Also, despite federal requirements that consumers must be informed that they have the option to answer only questions related to health coverage, asking SNAP-related questions before the health application is completed means that some consumers who would otherwise have finished the health application may instead fail to pursue a longer and more complex multi-program application through to completion.

As a third potential strategy, SNAP could be raised as a possibility when health coverage is renewed, rather than (or in addition to) during the initial application. At renewal, health consumers may experience less cognitive depletion than during the initial application for health coverage, since they typically must present less information to renew than to initially qualify for assistance and can continue with their current plan rather than select new insurance coverage from among available options. At renewal, consumers may thus have the time and cognitive resources needed to apply for SNAP without delay, rather than simply furnish contact information for later follow-up by the SNAP agency. However, both options—filing an on-line application for SNAP or simply providing contact information for later follow-up by state officials—could be presented so that different types of consumers could each have their needs met.

Challenges unique to joint enrollment campaigns

Several challenges face efforts to jointly enroll consumers into health and human services programs. First, during the 2014 open enrollment period, helping consumers sign up for health coverage was the sole priority of many Marketplaces and private-sector organizations focused on enrollment into health coverage. Little if any spare capacity remained to help applicants for health coverage also enroll into other benefit programs.[68] A similar exclusive focus is likely to continue in most states during the open enrollment period for 2015.

After calendar year 2014, federal grants to cover Marketplace administrative costs end. Starting in calendar year 2015, Marketplaces must be self-supporting. Even though navigators are a required function of Marketplaces, the end of federal grant funding for administrative costs may mean that fewer public-sector dollars will support the provision of enrollment assistance in state-based Marketplaces. This could signal a greater need for joint enrollment campaigns, but it also means that fewer resources will be available from health insurance Marketplaces to support such

efforts.

From the non-health side, one of the most promising potential joint enrollment campaigns—involving EITC—may face a serious challenge involving the timing of open enrollment. The open enrollment period for 2016 will run from November 1, 2015, through January 31, 2016.[69] This will probably involve no more than a two-week overlap with tax filing.[70] If subsequent open enrollment periods end before the tax filing season starts, joint EITC/IAP outreach will not be possible. Consumers will, however, be able to apply for Medicaid and CHIP when they file tax returns, since consumers can enroll into Medicaid and CHIP at any time without being limited to annual open enrollment periods.

Prospects for future integration efforts under the ACA

The same fundamental facts that created widespread interest around integration immediately following enactment of the ACA continue to be true today. The most important of these facts involve the considerable overlap between eligibility for IAPs and human services programs, as well as the large number of low- and moderate-income consumers who will qualify for and ultimately enroll into IAPs. The latter is likely to make IAP case records, particularly in Medicaid expansion states, the largest existing repository of information that could potentially be used to help determine eligibility for multiple need-based programs.

The second most important fact is the availability of enhanced federal funding for modernizing eligibility IT. With a cost-allocation exception that is now available through the end of 2018, states' development of integrated eligibility systems has become a much more feasible prospect than in the past.

Some of the greatest challenges to integration thus far have involved the demands of achieving the ACA's initial health coverage objectives. Past integration efforts make clear that these interagency initiatives typically require considerable time and attention before success is achieved. Such time and attention is particularly scarce, given the continuing requirements of ACA implementation.

The long trajectory of achieving the Affordable Care Act's goals has several key implications in terms of possible federal strategies for facilitating integration between health and human services programs. First, for the near-term, federal policymakers and others interested in supporting integration could consider supporting promising initiatives in a small number of states that have achieved substantial progress accomplishing the ACA's core health coverage objectives. With an above-average administrative capacity to implement such efforts, such states could be supported by both federal encouragement (with demonstration authority, if necessary) and foundation resources. Collaborating with federal partners, foundation initiatives could build on the examples furnished by prior efforts like the "Maximizing Enrollment" project of the Robert Wood Johnson Foundation and the "Work Support Strategies" project originally begun under the auspices of the Ford Foundation and now supported by other philanthropies as well. Such state-specific projects would seek to test integration approaches that take advantage of new possibilities offered by the ACA, developing tools that can then be used by other states once they transition out of the most administratively demanding early phases of ACA implementation. This federal effort could also offer recognition to states that are national leaders in streamlining and integrating health and human services programs.

Second, federal agencies could encourage state health agencies' implementation of integration

efforts as those agencies increasingly master the ACA's core health coverage tasks and develop the capacity to pursue integration initiatives. Above we quote a message from early 2012 in which federal agencies required states to prioritize readiness for the 2014 open enrollment period before creating eligibility systems that were integrated with human services programs. However, that same message urged states "to consider the benefits of interoperable systems and how system development could be staged," with "mechanisms for phasing … IT development such that the additional functionality needed to determine eligibility for human services programs can be added after the health components are operational."[71] The goal was not to prevent integration but rather to delay it until state health agencies were prepared to move forward.

Regulations require the use of human services data to verify applicants' attestations of financial eligibility for Medicaid and CHIP and to renew beneficiaries' coverage when such data are found useful. Some states are not yet fully implementing these and related provisions.[72] ACA Section 1413(c)(3)(A) requires states, whenever feasible, to use data from human services programs to verify, renew, and modify eligibility for Medicaid. This provision requires all IAPs "to the maximum extent practicable" to "establish, verify, and update eligibility…. on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act." The latter sections reference virtually all human services programs.[73] Subparagraph (B) creates an exception to these requirements involving "circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching … outweigh its expected gains in accuracy, efficiency, and program participation." This has left room for federal officials to give states time to focus their limited administrative capacity on meeting the fundamental requirements of ACA implementation. As time passes, however, it will become increasingly feasible for Medicaid programs to proactively access and use data in the hands of human services programs to facilitate eligibility determination.

In addition, while state Medicaid programs are required to use data from certain human services programs to verify attestations of applicants' financial eligibility for Medicaid and to renew beneficiaries' coverage administratively, these data typically are used to verify the amount of specific types of income (e.g., wages) available to the applicant or beneficiary. In the future, allowing (and encouraging) state Medicaid programs to use the actual income determination made by another government program more broadly to verify the total income (counting all income sources) attested by the individual, even though the two programs may use somewhat different methodologies for calculating total income, could be considered. State Medicaid programs could increase the efficiency of eligibility determination and reduce burdens on consumers by leveraging the powerful predictive effects of income determinations already made by human services programs, as follows:

- *Verifying applicant eligibility*. If an applicant attests, under penalty of perjury, to components of current monthly income that show total MAGI at Medicaid levels, data showing receipt of certain human services benefits would establish a high probability of financial eligibility, as indicated earlier. Under the approach discussed here, a state could classify such data as "reasonably compatible" with those attestations, verifying financial eligibility without asking the applicant for further documentation that the state would need to process.[74]

- *Administrative renewal*. If a beneficiary coming up for renewal is receiving human services benefits like SNAP, specific data elements from records of the human services program (such as information about wages) are already used to provide "reliable information"[75]

demonstrating that the beneficiary continues to qualify for Medicaid, thus triggering administrative renewal.[76] The beneficiary is sent a notice describing the renewal decision and explaining that the beneficiary is legally required to correct any errors, including by providing notice of changed household circumstances. Unless corrections are received, coverage continues.

However, data showing receipt of benefits like SNAP would establish more than a 90 percent likelihood of continuing eligibility, as noted above. In such cases, administrative renewal would likely increase the overall accuracy of redeterminations, because the opportunities for incorrect procedural terminations outnumber the opportunities for incorrect procedural renewal by more than a nine-to-one ratio.[77] It also might be possible to consider allowing states to use data showing the *receipt* of such human services benefits as the basis for administrative renewal, without manually "cross-walking" the specific details of human services case records into the technically distinct categories that Medicaid uses to count income and to define households, although this would likely require a waiver under Section 1115 of the Social Security Act.[78] By increasing the number of administrative renewals states can process, this approach would reduce states' overall burdens.

- *Streamlined and telephonic renewals.* As noted earlier, when the receipt of human services benefits establishes a very high likelihood of Medicaid eligibility, the approach discussed here would let states classify the eligibility determinations of human services programs as evidence that is "reasonably compatible" with sworn attestations of income at Medicaid levels. If a state has data showing the receipt of such human services benefits, and the beneficiary makes sworn attestations about components of income that show MAGI below applicable thresholds, the state would renew financial eligibility without seeking any additional information from the consumer.[79]

  Renewals can be done through any of the modalities allowed for applications.[80] Accordingly, a state could renew financial eligibility by simply calling the beneficiary and obtaining a telephonic, sworn attestation of relevant income components that result in MAGI below the applicable eligibility threshold. As noted above in connection with Louisiana's successful approach to renewing children's health coverage, low-income families are typically more willing to provide information by phone than by completing forms and returning them to the state.

ACA Section 1561 provides a second example of statutory provisions that support integration between health and human services programs. As noted earlier, this section requires HHS to "develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs," including "electronic matching against existing Federal and State data," and "systems verification of eligibility." Standards and protocols approved by the HHS Secretary call for:

- "the consistent, efficient and transparent exchange of data elements between programs," with agreed-upon "standards for core data elements commonly exchanged across health and human service programs," using the National Information Exchange Model (NIEM);

- federal agencies "shar[ing] data with States for verification of a consumer's initial eligibility, renewal and change in circumstances for [IAPs] … us[ing] a set of standardized Web services that could also support the eligibility determination process in other health and human services programs such as SNAP and TANF;" and

- "development of a Federal reference software model, implementing standards for obtaining verification … information from Federal agencies and States to ensure a consistent, cost-effective and streamlined approach across programs" which would include "interfaces to Federal, State or other widely-available data sources and tools."

The recommendations also call for health and human services programs to "express business rules using a consistent, technology-neutral standard format, congruent with the core data elements identified through the NIEM process."[81]

These recommendations set a high bar. An ongoing challenge for federal agencies is to gauge the evolving capacity of their heterogeneous state health and human services partners. That evaluation can help define a range of expectations and corresponding set of federal actions that encourage the most rapid feasible forward movement towards implementing these recommendations.

Aside from potential policy responses to the potential for a gradual and ongoing increase in states' capacity for integration efforts, additional research into integration and coordination issues also deserves consideration. For example:

- Qualitative research could examine the perspectives of human services program administrators and front-line staff about the IT and other institutional arrangements that would make it feasible for them to facilitate the enrollment of program participants into IAPs.

- Qualitative research could explore states' needs for technical assistance in achieving greater program integration, particularly in states that have made some progress toward integration but may need additional resources and guidance to achieve their goals. Documenting successful health/human services agency partnerships for promoting integration could provide helpful examples for other states.

- Qualitative research could explore the data sources accessible to child support enforcement agencies as well as the data matching expertise of such agencies. Such agencies often play a central role in brokering interagency data arrangements, and it could be helpful to gain a greater understanding of their capacities and potential use in future integration efforts.

- Qualitative and quantitative research could compare states that grant automatic, "deemed" Medicaid eligibility to SSI recipients with states that do not. Such comparisons could analyze administrative costs, enrollment, and the accuracy of eligibility determinations.

- Qualitative research could explore the opportunities and risks presented by joint enrollment efforts serving multiple programs, including campaigns that are publicly funded as well as those that are privately sponsored.

- Qualitative research could analyze how (if at all) Marketplaces are linking IAP applicants to human services programs for which they may qualify, either through application forms, renewal procedures, navigators with human services expertise, or referrals to human services agencies or on-line forms. That research could also explore the impact of these approaches on access to human services benefits.

- Quantitative research could provide more refined analysis of overlaps between health and human services program eligibility and enrollment. This would include distinguishing between Medicaid expansion and non-expansion states in estimating the overlap between

IAP eligibility and human services program participation. Also, when national survey data become available that show participation levels under the ACA, analyses could explore the relationship between IAP *enrollment* and human services participation, not just IAP *eligibility* and human services participation. One-year American Community Survey estimates of health coverage in 2013, by state, were released on September 18, 2014.[82] If that same schedule applies to 2014 estimates, they should be available by September 2015.

- Qualitative research and analysis could develop metrics for assessing state progress in integrating eligibility determination, enrollment, and renewal of health and human services programs. Some metrics could involve process measures, such as the percentage of applications and redeterminations that used data matches with other programs to help decide eligibility. Other metrics could focus on outcomes. For example, a recent Urban Institute paper estimated "joint participation rates" for several states participating in the Work Support Strategies Project (WSS)—that is, among children and adults who qualified for both Medicaid and SNAP, the percentage who participated in both programs.[83]

- Mixed methods research, including both qualitative and quantitative components, could build on this WSS work and use later, post-ACA implementation data to explore why some states do better than others in achieving high joint participation rates.

Conclusion

The single greatest success achieved by integration under the ACA thus far probably involves states' use of SNAP data to enroll over 700,000 uninsured people into Medicaid, without consumers needing to complete full Medicaid application forms, and without states needing to make MAGI income determinations.[84] This step lessened rather than increased administrative burdens on state health officials. Other integration initiatives offer great promise as well, but few have moved forward, in part because they call upon state health programs to devote time and effort that, as a general rule, have not been available for anything other than meeting the most direct health coverage goals of ACA implementation.

In the coming years, an increasing number of state health agencies are likely to achieve the ACA's core health expansion objectives. This will leave room for them to engage in other initiatives, taking advantage of the opportunities created by the ACA for integrating and coordinating eligibility determination, enrollment, and renewal between health and human services programs. The timing of these integration opportunities is likely to vary by state. However, the recent extension of both enhanced Medicaid funding for systems improvements and the exception to usual cost-sharing rules provides a powerful platform for developing an IT infrastructure that can greatly facilitate integration efforts. Continuing support and encouragement from federal agencies will almost certainly play a central role in facilitating successful integration efforts as new prospects for progress emerge in the coming years.

Notes

[1] Congressional Budget Office. Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act. April 2014 – January 2015 Baseline.

[2] Whitmore Schanzenbach, Diane. "Experimental Estimates of the Barriers to Food Stamp Enrollment." Institute for Research on Poverty, Discussion Paper no. 1367-09. Sept. 2009.

[3] Stan Dorn, Julia Isaacs, Sarah Minton, Erika Huber, Paul Johnson, Matthew Buettgens, and Laura Wheaton. "Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act," *Integrating Health and Human Services Programs and Reaching Eligible Individuals Under the Affordable Care Act*, December 23, 2013, Washington, DC: Urban Institute, http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_integrationproject.pdf. Unless otherwise noted, this report is the source of all of the executive summary's estimates of overlapping eligibility and benefit receipt involving health and human services programs.

[4] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_PromissingPractices.pdf.

[5] "A-87 Exception Toolkit for Human Service Agencies," American Public Human Services Association, July 2014. "Early Lessons from the Work Support Strategies Initiative: Planning and Piloting Health and Human Services Integration in Nine States," Olivia Golden, March 2013.

[6] Congressional Budget Office 2015.

[7] ASPE produces projections of ACA enrollment as well; see http://aspe.hhs.gov/health/reports/2012/ACA-Research/index.cfm, "How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period?," November 10, 2014.

[8] ACA §1413.

[9] ACA §1561.

[10] Center for Medicare & Medicaid Services (CMS). 2011. Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010. Federal Register Volume 76, Number 159 (Wednesday, August 17, 2011). Pages 51148-51199. (Accessed July 23, 2012). That same CMS decision established that 75 percent federal matching funds, rather than the standard 50 percent match that applies to most administrative costs, will cover operational costs of IT used to help determine Medicaid eligibility.

[11] See, e.g., Office of Management and Budget, OMB Circular A-87 Revised, http://www.whitehouse.gov/omb/circulars_a087_2004 (Accessed July 23, 2012).

[12] Letter from Cindy Mann, CMS, to Tracey Wareing and Matt Salo, October 28, 2014. The 90 percent federal matching rate for Medicaid IT investments was also originally going to end on December 31, 2015, but it has now been extended indefinitely.

[13] Dorn, Stan and Elizabeth Lower-Basch. 2012. *Moving to 21st-Century Public Benefits: Emerging Options, Great Promise, and Key Challenges*. Prepared by the Urban Institute for the Coalition for Access and Opportunity.

[14] Work Support Strategies: Streamlining Access, Strengthening Families. Washington, DC: The Ford Foundation, the Urban Institute, the Open Society Foundations, and the Annie E. Casey Foundation. http://www.urban.org/worksupport/about.cfm (Accessed July 23, 2012).

[15] CMS. *Medicaid & CHIP: August 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*, October 17, 2014, http://www.medicaid.gov/affordablecareact/medicaid-moving-forward-2014/downloads/august-2014-enrollment-report.pdf.

[16] CMS, Center for Medicaid and CHIP Services (CMCS). *States Using Multi-Benefit Applications As an Alternative Application, As of June 2014*.

[17] Adams, Gina and Monica Rohacek. 2010. *Child Care Instability: Definitions, Context, and Policy Implications.* Washington, DC: The Urban Institute.

[18] State Health Access Data Assistance Center. "State Health Access Program State Medicaid Eligibility System Survey: Report on the Modernization of State Medicaid Eligibility Systems." June 2012.

[19] Government Accountability Office. *Means-Tested Programs: Information on Program Access Can Be an Important Management Tool*. March 2005, GAO-05-221. http://gao.gov/assets/250/245577.pdf.

[20] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_integrationproject.pdf.

[21] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_PromissingPractices.pdf.

[22] Iyengar, Sheena S., and Mark R. Lepper. 2000. When Choice is Demotivating: Can One Desire Too Much of a Good Thing? Journal of Personality & Social Psychology 79, no. 6: 995-1006. Sethi-Iyengar, Sheena, Gur

Huberman, and Wei Jiang. 2004. How Much Choice Is Too Much?: Contributions to 401(k) Retirement Plans. Pension Design and Structure: New Lessons from Behavioral Finance, 83-95. New York: Oxford University Press.; Iyengar, Sheena S. and Wei Jiang. 2005. The Psychological Costs of Ever Increasing Choice: A Fallback to the Sure Bet. Working Paper.; Millett, Christopher, Arpita Chattopadhyay, and Andrew Bindman. 2010. Unhealthy Competition: Consequences of Health Plan Choice in California Medicaid. Highlights from the Commonwealth Fund-Supported Studies in Professional Journals. The Common Wealth Fund.; Hanoch, Yaniv and Thomas Rice. 2006. Can Limiting Choice Increase Social Welfare?:The Elderaly and Health Insurance. The Milbank Quarterly 84(1): 37-73.; Frank, Richard and Karine Lamiraud.. 2008. Choice, Price Competition and Complexity in Markets for Health Insurance. Working Paper 13817. National Bureau of Economic Research (NBER) Working Paper Series. Cambridge, MA: NBER.

[23] Liebman, Jeffrey and Richard Zeckhauser. 2008. Simple Humans, Complex Insurance, Subtle Subsidies. Working Paper 14330. National Bureau of Economic Research (NBER) Working Paper Series. Cambridge, MA: NBER.

[24] Bertrand, Marianne, Sendhil Mullainathan, and Eldar Shafir, 2004. Memos to the Council of Behavioral-Economics Advisors: A Behavioral-Economics View of Poverty. AEA Papers and Proceedings 94(2): 419-423.; Beshears, John, James J. Choi, David Laibson, and Brigitte Madrian. 2006. The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States. Working Paper 12009. National Bureau of Economic Research (NBER) Working Paper Series. Cambridge, MA: NBER.; Laibson, David. 2005. Impatience of Savings. Research Summary. NBER Report Fall 2005. National Bureau of Economic Research. p.6-8.

[25] Beshears, John, James J. Choi, David Laibson, and Brigitte Madrian. 2006. Simplification and Saving. Working Paper 12659. National Bureau of Economic Research (NBER) Working Paper Series. Cambridge, MA: NBER.; Choi, James, David Laibson, and Brigitte C. Madrian. 2004. Defined Contribution Plans for Passive Investors. July 5.; Liebman and Zeckhauser, 2008, op. cit.; Sunstein, Cass R. and Richard H. Thaler. 2003. Libertarian Paternalism Is Not an Oxymoron. The University of Chicago Law Review 70(4): 1159-1202.

[26] Hill, Ian, et al., 2004. Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Cross-Cutting Report on the Findings from Ten State Site Visits. Prepared by the Urban Institute and Mathematica Policy Research, Inc., for the U.S. Department of Health and Human Services. http://www.urban.org/UploadedPDF/1001343_schip.pdf; Flores, G., et al. 2005. Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children, Pediatrics, 116 (6): 1433–1441; and Bettinger, Eric P. , Bridget Terry Long, Philip Oreopoulos, and Lisa Sanbonmatsu. 2009. The Role of Simplification and Information in College Decisions: Results from the H&R Block FAFSA Experiment. National Bureau of Economic Research Working Paper 15361.

[27] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_BehavioralEconomics.pdf.

[28] http://aspe.hhs.gov/hsp/14/IntegrationProject/ib_ModernizeEligibilitySystems.pdf.

[29] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_PromissingPractices.pdf.

[30] A similar deemed eligibility approach could potentially be used with Medicaid categories that base financial eligibility on income alone without considering asset values. Since January 2014, financial eligibility has been based on income alone for most Medicaid categories that do not limit coverage to people with disabilities and people age 65 or older.

[31] All CAP demonstrations share certain features, including the following: (1) Everyone in a CAP-participating household must receive SSI. (2) States provide two or more standard benefits that vary by household shelter costs or a variable benefit that is calculated using one of two or more standard shelter expenses. (3) All households with high out-of-pocket medical or shelter costs are encouraged to apply for SNAP using standard procedures, which measure those costs with some specificity and use them to help determine benefits. If these households go through standard SNAP procedures, they will likely receive more benefits than those calculated using CAP's simplified, more streamlined methods. (4) States that operate CAP demonstrations must maintain benefit cost neutrality, as described in the body of the report, below. (5) States should increase CAP benefits in October if SNAP maximum allotments rose and decrease CAP benefits in January if SSI benefits increased—changes that help keep CAP benefits aligned to those paid under standard SNAP procedures.

In some important ways, CAP demonstrations differ from one another. SSA offices in some states have modified their SSI application intake screens to ask several additional questions from applicants interested in receiving SNAP along with SSI. One such question asks about shelter expenses, which are not relevant to SSI eligibility or benefit levels. However, applicants who answer these questions to obtain CAP SNAP benefits cannot receive the latter until they are found eligible for SSI. They are thus informed that, to get SNAP more rapidly, they

can apply directly to a SNAP office. Other states omit this process, mailing a very simplified CAP/SNAP application to SSI recipients not currently receiving SNAP. Some states using the latter model have waivers that let them mail SSI recipients electronic benefit transfer (EBT) cards loaded with the smallest CAP standardized benefit. This lets SSI recipients who are known to be CAP-eligible obtain nutrition assistance without completing even the simplified application form. Along with the EBT card, the state sends a notice that if the recipient's shelter expenses exceed a threshold value, the recipient can obtain increased benefits by submitting proof of such expenses. Consent to SNAP enrollment occurs when the SSI beneficiary uses the EBT card to purchase food.

[32] Scott Cody and Carole Trippe. "Trends in FSP Participation Rates: Focus on August 1995." October 17, 1997, Washington, DC: Mathematica Policy Research, Inc., prepared for U.S. Department of Agriculture (USDA), Food and Consumer Services.

[33] Esa Eslami. "Trends in Supplemental Nutrition Assistance Program Participation Rates: Fiscal Year 2010 to Fiscal Year 2012." July 2014, Washington, DC: Mathematica Policy Research, prepared for USDA, Food and Nutrition Service, Office of Policy Support.

[34] Barbara Murphy. "Combined Application Projects: An Analysis of their Impact on the Supplemental Nutrition Assistance Program," USDA Food and Nutrition Service, Sept. 2010 draft (Contract # AG-3198-D-08-0111).

[35] States must adjust CAP benefit amounts if, based on a periodic random sample of CAP households, adjustment appears required to achieve such "benefit cost neutrality."

[36] While Utah achieved increased operational efficiency, no hard evidence documents increased participation by eligible individuals.

[37] Whitmore Schanzenbach, Diane. "Experimental Estimates of the Barriers to Food Stamp Enrollment." Institute for Research on Poverty, Discussion Paper no. 1367-09. Sept. 2009.

[38] Bettinger, Eric P., Bridget Terry Long, Philip Oreopoulos, and Lisa Sanbonmatsu, "The Role Of Simplification And Information In College Decisions: Results From The H&R Block FAFSA Experiment," National Bureau of Economic Research Working Paper 15361 (September 2009). Bettinger and colleagues found that, among dependents, completing the form on behalf of the family raised the proportion submitting applications from 40.2 percent to 55.9 percent—a 40 percent relative increase. Among independent adults, the form completion intervention nearly tripled the likelihood of filing for student aid, raising the form submission rate from 13.8 percent to 39.5 percent.

[39] J. Ruth Kennedy. "Express Lane Eligibility Using SNAP Data," *Max Enroll State to State Exchange*, New Orleans, LA, March 25, 2010, http://www.nashp.org/sites/default/files/express.lane_.eligibility.using_.snap_.pdf; Stan Dorn, Margaret Wilkinson, and Sarah Benatar. "Case Study of Louisiana's Express Lane Eligibility." *CHIPRA Express Lane Eligibility Evaluation*. Washington, DC: Urban Institute, 2014.

[40] Colby, Maggie and Brenda Natzke. "Utilization of Services by ELE Enrollees." *CHIPRA Express Lane Eligibility Evaluation*. Princeton, NJ: Mathematica Policy Research, 2013. To analyze the impact of ELE enrollment on utilization, researchers used a regression analysis to adjust the characteristics of ELE enrollees, in terms of age, gender, geography, and other factors, to fit the characteristics of Medicaid children enrolling through other methods.

[41] Dorn, Stan, Margaret Wilkinson, and Sarah Benatar. "Case Study of Louisiana's Express Lane Eligibility: Final Report." *CHIPRA Express Lane Eligibility Evaluation*. Washington, DC: Urban Institute. August 2013.

[42] Murphy, Barbara. *Combined Application Projects: An Analysis of their Impact on the Supplemental Nutrition Assistance Program.* USDA Food and Nutrition Service, Sept. 2010 draft (Contract # AG-3198-D-08-0111).

[43] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_integrationproject.pdf. Except as otherwise noted, this report is the source of all estimated relationships between human services program receipt and eligibility for IAPs under the ACA as stated in this section of the report.

[44] If one adds CHIP participants, the applicable percentages rise to 97 percent for SNAP, 85 percent for WIC, and 87 percent for LIHEAP, 90 percent for CCDF, and 92 percent for housing subsidies.

[45] Karen E. Cunnyngham. "Reaching Those in Need: State Supplemental Nutrition Assistance Program Participation Rates In 2011," February 2014, Washington, DC: Mathematica Policy Research, prepared for USDA, Food and Nutrition Service.

[46] Plueger, Dean. 2009. "The EITC Participation Rate for Tax Year 2005," *Internal Revenue Service Bulletin*.

[47] These estimates are based on proxy measures, described in Dorn, Isaacs, et al. *Integrating Health and Human Services Programs and Reaching Eligible Individuals Under the Affordable Care Act*.

[48] "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," Center for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS), May 17, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

[49] Within 6 weeks (by November 15, 2013), the four states that first implemented these strategies—Arkansas, Illinois, Oregon, and West Virginia—had enrolled approximately 63,000, 36,000, 70,000, and 54,000 people, respectively. Guyer, Jocelyn, Tanya Schwartz and Samantha Artiga, *Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion,* Manatt Health Solutions and the Kaiser Commission on Medicaid and the Uninsured, November 19, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf. Since the initial implementation of these targeted enrollment strategies, the number enrolled has increased. For example, Oregon reached more than 123,000 people by February 6, 2014. "Legislature Aimed at Improving Access to Cover Oregon, IT Oversight Bills." *Cascade Business News*. Feb 18, 2014. http://www.cascadebusnews.com/news-pages/e-headlines/4982-legislature-aimed-at-improving-access-to-cover-oregon-it-oversight-bills.

[50] See, e.g., 42 CFR 435.948.

[51] Sometimes, FMAP is referred to as "federal financial participation," or FFP, a term that generically encompasses federal matching funds; FMAP is the form that FFP takes within the Medicaid program.

[52] CMS. "Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities: Final Rule," *Federal Register*, Vol. 76, No. 75, April 19, 2011, 21950-21975.

[53] Letter from Cindy Mann, CMCS/CMS/HHS, Kevin Concannon, FNS/USDA, George Sheldon, ACF/HHS, and Steve Larsen, CCIIO/CMS/HHS, to State Exchange Grantees, Medicaid and CHIP Directors, and Health and Human Services Directors, January 23, 2012. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-01-23-12.pdf.

[54] Kaiser Family Foundation. "Integration and Upgrade of Medicaid and CHIP Eligibility Systems" (as of January 2013), *State Health Facts,* http://kff.org/medicaid/state-indicator/medicaid-chip-eligibility-systems/.

[55] http://aspe.hhs.gov/hsp/14/IntegrationProject/ib_ModernizeEligibilitySystems.pdf.

[56] Jessica Kahn, CMS, personal communication, 2014.

[57] *National Federation of Independent Business v. Sebelius*, 567 US 1 (2012).

[58] Kaiser Family Foundation. "Current Status of State Medicaid Expansion Decisions," http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/, updated January 27, 2015.

[59] Following are several examples. Alabama, Louisiana, and South Carolina needed to develop data exchange systems between SNAP and Medicaid before they could implement ELE. Hoag, Sheila, et al. *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*. December 2013, Washington, DC: ASPE/HHS, http://aspe.hhs.gov/health/reports/2013/ELE/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf; since October 2013, Washington state has distinguished MAGI-based Medicaid records from SNAP and TANF records, with barriers between those record sets, even if the same person enrolls in Medicaid and in SNAP, Public Consulting Group. "Initial Findings Report," *Washington State Medical and Public Assistance Eligibility Study,* February 19, 2014, Olympia, WA: Washington State Office of Fiscal Management, http://ofm.wa.gov/reports/medicalpublicassistancestudy.pdf. The entities determining eligibility for LIHEAP and housing subsidies, including their eligibility IT systems, are often housed outside the social services agencies that have historically determined Medicaid eligibility. For a list of state agency LIHEAP contacts, see ACF, *LIHEAP State and Territory Contact Listing,* http://www.acf.hhs.gov/programs/ocs/liheap-state-and-territory-contact-listing. Local public housing authorities, rather than state or county social services offices, determine eligibility for public housing and housing choice vouchers. U.S. Department of Housing and Urban Development (HUD), *HUD's Public Housing Program*, http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog; HUD, *Housing Choice Vouchers Fact Sheet*, http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/about/fact_sheet. Also Megan Lape, American Public Human Services Association, personal communication, 2014.

[60] Hoag et al. 2013.

[61] Guyer et al. 2013.

[62] As of August 2014, seven states had gained approval for using SNAP data for targeted enrollment programs. CMS. "New State Medicaid & CHIP Targeted Enrollment Strategies (As of August 1, 2014)," *Targeted Enrollment Strategies*, http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html.

[63] http://aspe.hhs.gov/hsp/14/IntegrationProject/rpt_BehavioralEconomics.pdf.

[64] For example, a state could require plans chosen by default to contact the consumer and obtain consent before capitated payments begin (or before such plans receive more than a limited number of payments). Arkansas and West Virginia have taken similar steps to pursue a targeted enrollment initiative, where agency staff followed up a mailing with phone calls, urging nonrespondents to enroll. Under the alternative suggested here, managed care organizations, rather than government employees, would do the necessary follow-up, in response to financial incentives created by the state.

[65] Ruth Kennedy, Louisiana Department of Health and Hospitals, personal communication, 2014.

[66] If such enrollees obtain coverage by applying through the Marketplace, rather than the social services offices that also administer human services programs, those who qualify for but do not receive human services benefits may never learn about their potential qualification for the latter assistance. Depending on how the IAP application process is structured, consumers who do know about human services may need to submit the same information twice, once to qualify for IAPs and a second time to qualify for human services benefits; those applications may need to be submitted at two different offices, websites, or call centers.

[67] CMCS, States Using Multi-Benefit Applications.

[68] APHSA, July 2014.

[69] CMS, "HHS Notice of Benefit and Payment Parameters for 2016: Final Rule," Federal Register, Vol. 80, Feb. 27, 2015, https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-03751.pdf (pdf copy).

[70] January 20 was the formal start date of tax filing season for all taxpayers in 2015. However, the IRS's "Free File" program began operation on January 16, 2015. IRS. "IRS Starts 2015 Tax Season; Free File Opens Tomorrow, E-File Tuesday; Expanded Online Services Enable People to Learn About New Health Care Provisions," January 15, 2015, http://www.irs.gov/uac/Newsroom/IRS-Starts-2015-Tax-Season;-Free-File-Opens-Tomorrow,-EFile-Tuesday.

[71] Mann, Concannon, Sheldon, and Larsen, 2012.

[72] See, for example, California's verification plan for Medicaid, available at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Eligibility-Verification-Policies/Downloads/California-Verification-Plan-Template-FINAL.PDF. Other states, like Washington, claim in their verification plans that they will use SNAP records, but in fact do not. Washington's verification plan is available at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Eligibility-Verification-Policies/Downloads/Washington-Verification-Plan-Template-Final.pdf. For a description of Washington's lack of integration between MAGI-based Medicaid and human services programs, see Public Consulting Group, Initial Findings Report.

[73] Section 1137, for example, references unemployment insurance, SNAP, TANF, SSI, Medicaid, and quarterly wage records (and arguably child support enforcement and federal income tax data). Section 1942 cross-references the National Directory of New Hires as well as all agencies that can provide Express Lane Eligibility under Social Security Act Section 1902(e)(13)(F), including, in addition to those referenced earlier in this endnote, CHIP programs, Head Start programs, the National School Lunch Program, subsidized child care programs, housing subsidy programs, various programs that serve Native Americans and American Indians, etc.

[74] 42 CFR 435.952. For a general discussion of reasonable compatibility, see CMCS. April 19, 2012. *Medicaid and CHIP in 2014: A Seamless Path to Affordable Coverage: Application, Verification and Renewals*. http://www.medicaid.gov/State-Resource-Center/Downloads/4-19-12-Application-Verification-Renewals-Slides.pdf.

[75] 42 CFR 435.916(a)(2). In its preamble to the final rule, CMS described the proposed regulation, the relevant language of which did not change in the final rule, as follows:

> "Proposed § 435.916(a)(2) sought to codify a longstanding policy, explained in a letter to State Medicaid Directors on April 7, 2000, available at http://www.cms.gov/smdl/downloads/smd040700.pdf, that States must rely on information that is available and that the State considers to be accurate to renew eligibility. …. For example, if a family has recently verified income, household size, and residency as part of a recent SNAP review, then the Medicaid agency would typically use that information to renew Medicaid eligibility."

CMS, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," Federal Register, Vol. 77, No. 57, March 23, 2012, 17144, 17181. This explanation highlights both (1) the permitted use of SNAP records in renewing Medicaid eligibility, exemplifying the role potentially played by human services data more broadly; and (2) the flexibility given to states in identifying the data that are considered to be sufficiently accurate to trigger

administrative or *ex parte* renewal. Even before the ACA, Medicaid regulations required states to make *ex parte* redeterminations of eligibility, whenever possible. This means that renewal was required, without contacting the enrollee, whenever information available to the state demonstrated continuing eligibility, and the state had an affirmative obligation to seek out such information on its own before contacting the enrollee. See, e.g., Health Care Financing Administration. April 7, 2000, and April 22, 1997, *Dear State Medicaid Director* letters, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040700.pdf, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD042297.pdf.

[76] Final Medicaid regulations specifically require administrative renewal for Medicaid eligibility categories that use MAGI—namely, coverage for children, parents, pregnant women, and certain other non-elderly and non-disabled adults—but states may also use administrative renewal with other Medicaid beneficiaries.

[77] Under a broad range of assumptions, earlier analysis found that, when 90 percent of a beneficiary group qualifies for Medicaid, renewing the group administratively, rather than through manual procedures: (1) reduces the net number of mistaken redetermination outcomes by approximately 56 to 79 percent, because, in such a group, the number of procedural terminations of eligible beneficiaries prevented by administrative renewal greatly exceeds the number of renewals of ineligible beneficiaries caused by administrative renewal; and (2) lowers the number of manually conducted redeterminations by an estimated 60 to 73 percent, thus generating administrative savings. Stan Dorn and Matthew Buettgens, *Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs*, December 2012, Washington, DC: Urban Institute, http://www.urban.org/publications/412921.html.

[78] In commenting about state flexibility under Social Security Act Section 1902(e)(13) to use the receipt of SNAP benefits as the basis for granting Medicaid eligibility temporarily through targeted enrollment programs, CMS wrote in the preamble to the final ACA Medicaid eligibility rule, "States may be able to develop a process similar to that provided under section 1902(e)(13) of the Act through a demonstration if the requirements of section 1115 of the Act are met." Requirements under the latter section include accomplishment of the purposes of the Medicaid statute, opportunities for public notice and comment, evaluation, and, under longstanding administrative interpretation, federal budget neutrality. CMS. "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 77 Fed. Register 17144, 17171 (March 23, 2012).

[79] At redetermination, Medicaid and CHIP programs "may request from beneficiaries only the information needed to renew eligibility." 42 C.F.R. § 435.916(e). Moreover, the same "reasonable compatibility" standards that are used for initial applications also govern renewals. 42 C.F.R. § 435.916(a)(3)(ii), cross referencing 42 C.F.R. § 435.952.

[80] 42 C.F.R. § 435.916(a)(3)(B), cross-referencing 42 C.F.R. § 435.907(a).

[81] For the text of the recommendations as adopted, see "Patient Protection and Affordable Care Act Section 1561 Recommendations: Toward a More Efficient, Consumer-Mediated and Transparent Health and Human Services Enrollment Process," in Administration of Children and Families, U.S. Department of Health and Human Services, *Interoperability Toolkit 2011,* http://www.acf.hhs.gov/sites/default/files/assets/interoperability_toolkit.pdf.

[82] U.S. Census Bureau, "2013 Release Schedule," *American Community Survey*, Updated August 7, 2014, http://www.census.gov/acs/www/data_documentation/2013_release_schedule/.

[83] Laura Wheaton, Victoria Lynch, Pamela Loprest, and Erika Huber. *Joint SNAP and Medicaid/CHIP Program Eligibility and Participation in 2011,* September 2014, Washington, DC: Urban Institute, http://www.urban.org/publications/413246.html.

[84] CMS, "Medicaid and CHIP: November 2014 Monthly Applications, Eligibility Determinations and Enrollment Report," February 2, 2015.