

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Reforming New York's Medicaid Eligibility Process: Lessons from Other States

About the Medicaid Institute at United Hospital Fund

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

About United Hospital Fund

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

Medicaid Institute at United Hospital Fund

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Reforming New York's Medicaid Eligibility Process: Lessons from Other States

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AT UNITED HOSPITAL FUND BY

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Foreword

With the responsibility of covering more than four million low-income New Yorkers, including many of our sickest and most vulnerable state residents, Medicaid is a cornerstone of New York's health insurance system and the largest single component of our health care economy. Medicaid's importance—measured in both people and dollars—is matched only by the complexity of federal, state, and local laws, regulations, and operational roles that govern how the program must operate.

Since the United Hospital Fund launched the Medicaid Institute in 2005—to provide information and analysis explaining New York's Medicaid program, with the goal of helping all stakeholders redesign, restructure, and rebuild the program—we have sought to develop a shared vision of how Medicaid can better organize and deploy its resources to meet its most important challenges.

This latest Medicaid Institute report, *Reforming New York's Medicaid Eligibility Process: Lessons from Other States*, brings together three important themes that are at the heart of the Institute's work. First, improving the enrollment and retention of eligible New Yorkers is essential not only to increasing health insurance coverage but also to better managing patient care. Second, the structures and processes by which the state and fifty-eight local governments operate New York's Medicaid program—by some measures comparable to a Fortune 50 company—must allow the program to be run effectively and efficiently. Third, as we have often found, to advance our strategic thinking and analytic work we must look to states that have been tackling similar challenges in a variety of ways, to gain valuable insights into the opportunities and options available to us.

Prepared by a senior team at Health Management Associates, and reflecting significant contributions of time and attention from senior Medicaid officials in New York and other states, this report builds on several years of Medicaid Institute work on how best to administer this crucial program. That work remains a priority, as we will continue to explore how to operate Medicaid in a way that is most effective and consistent with state policy goals.

James R. Tallon, Jr.
President
United Hospital Fund

Executive Summary

Background and Introduction

New York's Medicaid program provides health coverage for 4.1 million low-income adults and children, persons with disabilities, and elderly adults. It is the largest state Medicaid program in the nation in terms of cost, with federal, state, and local spending totaling \$44.7 billion in federal fiscal year 2006.

New York has been a national leader in health coverage programs for low-income, uninsured children and families. Among the twenty largest states, New York has the lowest proportion of children without insurance, a significant achievement. Because the state is so populous, however, the number of individuals without health coverage remains very large, totaling 2.4 million children and adults under age 65. Significantly, 40 percent of those who remain uninsured are believed to qualify for health coverage through an existing program such as Medicaid or the State Children's Health Insurance Program (SCHIP).

Lack of health insurance is a significant public health issue. Studies have shown that persons without health coverage are much less likely to receive primary and preventive care. They are less likely to seek care even when it is urgently needed. When they do receive care, it is more likely for an untreated condition that has become worse, and more expensive to treat — and treatment is more likely provided in a hospital emergency department, where care is more expensive and less likely to be coordinated. These issues are especially important for uninsured children and persons with chronic conditions.

As part of its strategy to reduce the number of persons without health coverage, the New York Office of Health Insurance Programs, which administers the state's Medicaid program, has developed a multi-pronged approach to increasing coverage. This includes simplifying the eligibility rules, improving program administration, enhancing the use of technology, and creating messages that reduce the stigma of government programs. A priority has been to increase coverage among persons who are already eligible for programs such as Medicaid or SCHIP. One way of doing so is to be sure the administrative processes for application and enrollment are understandable and easy for applicants and beneficiaries to work with, and produce an accurate and timely determination of eligibility.

As New York works to improve the administration of its Medicaid program, it should be guided by the features acknowledged to be part of a high-quality eligibility process. The Southern Institute for Children and Families has identified the areas essential to creating an optimal eligibility process:

- Enrolling and retaining eligible children and families;
- Providing good customer service and low application-processing times;
- Expanding and improving state data capabilities through automated processes that allow for consistent decision-making across the state, eliminating variation from office to office; and
- Effectively putting policy into practice.

This report begins by examining the New York Medicaid eligibility structure and process. It then draws from the experience of selected states that have undertaken improvements in their Medicaid eligibility systems and processes in recent years, and identifies lessons that New York might consider as it seeks to improve its own Medicaid eligibility process.

Methodology

The information in this report is based on interviews with officials in New York and in six states selected specifically because they had undertaken initiatives in recent years to redesign their Medicaid eligibility systems. Included were four large states (California, Florida, Massachusetts, and Ohio), each with complex Medicaid eligibility systems and organizational structures, as well as two smaller states (Kansas and Louisiana) that had undertaken major initiatives to improve the performance of their Medicaid eligibility systems.

An interview instrument was designed to identify a number of key variables and issues for each state, including organizational structure, administrative responsibility for Medicaid eligibility, roles played by sister agencies and outside vendors, features and variations in the Medicaid application and eligibility determination process, the use of information technology systems, the use of measures of effectiveness, and specific state initiatives designed to improve the efficiency and performance of the Medicaid eligibility operational process.

New York's Eligibility Structure

The New York Medicaid eligibility structure is large, complex, and highly decentralized. The Department of Health (DOH) is the designated “Single State Agency” for Medicaid and, as such, has the statutory responsibility for all aspects of program design and administration. Within DOH, the Office of Health Insurance Programs (OHIP) has specific responsibility for all Medicaid program policy, including eligibility policy. OHIP does not, however, have operational responsibility for administering the Medicaid eligibility system. That responsibility is placed with a different agency, the Office of Temporary and Disability Assistance (OTDA). The Medicaid eligibility system operated by OTDA is part of a larger system that includes other health, public assistance, and social service programs.

OHIP is responsible for setting statewide eligibility policy for Medicaid, but operational responsibility for administering the eligibility process is further delegated to the fifty-eight local Departments of Social Services, agencies of county government and New York City. Medicaid applications may be submitted at these local departments or prepared by specially trained “facilitated enrollers” at various community organizations, which then send them on to a local department for eligibility determination. All Medicaid applications are processed by the local offices, where Medicaid eligibility workers are employees of local units of government. As an agency of the state, OHIP has no operational control over the implementation and administration of Medicaid eligibility policy at the local level.

DOH also contracts with two private vendors that interface with the OTDA eligibility system. One is the managed care enrollment broker for New York City and thirteen other counties, and the other manages eMedNY, the statewide Medicaid claims payment system.

In contrast to the New York State Medicaid eligibility process, with its decentralized structure and administration, New York's Children's Health Insurance Program administers a statewide eligibility system that is centralized rather than county-based. SCHIP applications are submitted through contracted managed care plans and eligibility is processed through a statewide centralized computer system.

Eligibility Administration in Selected States: Key Findings

While administrative practices in each of the six states reviewed in this study accomplish the mission of Medicaid eligibility determination and enrollment, they do so in ways that differ significantly from New York's structure. Examining how those states have structured their eligibility administration was useful as a way to identify options that New York policymakers may wish to consider.

The interviews with Medicaid eligibility officials in the six selected states identified a number of strategies, insights, and lessons they would offer to a state seeking to increase coverage through changes to the administration of program eligibility. These included:

Creation of a "Health Care Front Door" While New York and many other states continue to use a shared eligibility system for Medicaid and other social service programs, a number of states have moved over the last decade to create a new eligibility process dedicated to Medicaid (and other health programs) alone, and completely separate from cash assistance and other social service programs. The goal of a health care front door approach is to improve take-up rates and reduce the number of uninsured by making it easier to apply for and be enrolled in health coverage and by eliminating any stigma of "welfare" that might discourage persons from applying for coverage. This has become more relevant since the vast majority of persons covered by Medicaid today do not receive welfare/cash assistance, and Medicaid eligibility is no longer federally linked to welfare eligibility.

In states with a health care front door, the Medicaid agency is entrusted with sole responsibility for organizing and administering the Medicaid eligibility process, rather than using a system shared with or managed by the state's public assistance, human services, or social service agency. Several states offer applications for health coverage only, although some also make a unified application (for health care plus social services) available. In those states, the information technology system allows eligibility to be determined simultaneously for multiple health and social service programs, or applications to be forwarded to other agencies for processing. States using a health care front door approach believed it helps improve participation rates in Medicaid and other health programs.

Community Assistance States generally agreed that an important element of their strategy to increase health coverage was to involve community and provider organizations in outreach, consumer education, and assistance with applications. Because these community organizations are local resources, in the neighborhoods and close to the people they serve, they are trusted by applicants and enrollees. They are able to answer questions, suggest resources to address individual problems, and assist with applications. State officials regarded them as an invaluable resource.

Some states indicated that community assistance is most effective when it is coupled with access to the eligibility system through information technology tools such as electronic submission of applications or telephone application and renewal capabilities. Information systems can help states ensure that community and provider organizations have the best information possible and that their assistance is accurate.

State versus Local Administration Among the states selected for this analysis, those with state-operated eligibility structures were more likely to have adopted and successfully implemented significant operational reforms to improve performance of the eligibility process, compared to those with locally operated administration. This may indicate that state-administered programs are better positioned to undertake statewide improvements in workflow design and support reforms with upgraded technology.

Before statewide change can occur in county-operated programs, it is necessary to engage and secure the buy-in of local governments and their staffs. More time and effort may be required to establish and reach agreement on shared goals, implement policies and initiatives, achieve a consistent application of eligibility policy, and accomplish specific goals such as error reduction and improvements in enrollment rates. Officials in states with state-operated eligibility processes were more likely to believe that they were in a position to implement policies that would improve program performance and eligibility-related outcomes.

Performance Measurement State officials believed that there is value in establishing, monitoring, and measuring specific goals for performance. States that had identified specific goals and established measures of performance could demonstrate that they had achieved improvement toward those goals.

One state, for example, indicated that it had established a quality improvement process focused on improving retention. The process engaged front-line eligibility workers and encouraged “creative risk-taking” by staff. This state believed its success in improving retention was a direct result of this process. Another state that established performance measures reported that it had seen improvement in the targeted measures even in a period of caseload growth and understaffing. That state also used financial incentives, and believed that the combination of incentives and linking performance to specific measures helped move the program in the desired direction.

Most states in this review did not use the official Medicaid Eligibility Quality Control process, but had obtained a waiver to measure performance in a manner designed by the state. At the time of our survey, no state had official data from federal Payment Error Rate Measurement reviews; these reviews will not address issues relating to take-up rates and program penetration, but may eventually provide uniform data across state Medicaid and SCHIP programs on the accuracy of claims payment and beneficiary eligibility.

States emphasizing performance measurement appeared to have identified issues of particular importance to each state, rather than to have adopted a common set of measures used across states. States most often mentioned measuring accuracy, timeliness, total enrollment rates, and various indicators of reenrollment or retention, however.

Use of Information Technology States reported that information technology (IT) can be a powerful tool for improving Medicaid eligibility processes and achieving goals such as improved efficiency, accuracy, timeliness, and consistency. Without question, the effective use of IT can reduce errors when determining eligibility for applicants and when implementing new statewide eligibility policy. Eligibility determination algorithms, which can be implemented through electronic and Web-based applications, can ensure consistency by removing individual worker judgment from the process.

State officials reported that information technology was most useful in improving performance when it was paired with improvements in workflow for eligibility workers and simplified processes for applicants. When IT is used to communicate with and among eligibility workers, state officials believed it is also associated with improvements in retention and take-up rates.

Most of the case study states reported a preference that oversight of the eligibility computer system be consolidated under the management of the Medicaid program. At least one state, however, reported great satisfaction with a shared system that was managed by another program. Sophisticated technology, routine performance monitoring, and a close working relationship with the responsible agency were considered key to the success of the process for Medicaid.

Managing Program Change State officials in this review cautioned that it was important to be aware of the challenge of managing a significant process reform that affects front-line eligibility workers. Staff who have taken pride in their work for years under a long-used Medicaid eligibility structure cannot be expected to embrace significant change unless they understand how changes will improve the performance of the program. One state indicated that adoption of a more automated system was a significant cultural shift for front-line workers. Another state cited challenges related to changing the perception of Medicaid, from “welfare” to simply “health insurance.” Another described issues that arose as it created more centralized Medicaid and SCHIP eligibility processes.

State officials emphasized the importance of addressing issues of change that affect eligibility staff. States that successfully achieved significant improvements in eligibility administration indicated that they had engaged front-line staff in the development of new processes, and that training and communication were important at every stage of the process.

Conclusion

Every state is expected to design an approach to Medicaid eligibility that is fair, accurate, timely, efficient, and consistent. Each state crafts a structure that reflects its own policies, traditions, available funding, and technology at the time decisions are made. The fiscal integrity of the entire Medicaid program depends on the ability of the eligibility processes to assure that those who are enrolled into health coverage are those who should be enrolled, or retained in coverage when it is time to re-determine eligibility. Significantly, no one can be enrolled into Medicaid without applying for it. Thus, if a program like Medicaid is to serve all those it is intended to serve, the process must be easy to use and not discouraging to applicants.

This review was based on interviews with Medicaid eligibility officials in New York and six other states. State officials described a number of changes they had implemented to improve the performance of the Medicaid eligibility process. Common goals included improved take-up rates among eligible persons needing health coverage, reduced error rates and improved consistency, and increased efficiency. It was clearly important that each state decided what mattered most, and then focused on how to achieve that result, including how to measure, monitor, and, in some cases, reward progress.

Significant initiatives involved redesigning the eligibility process to create a “health care front door” for Medicaid and SCHIP; maximizing opportunities to use community-based organizations to assist with outreach and completion of applications; designing and monitoring specific measures of performance; using advances in information technology, including electronic applications and eligibility determination algorithms, to support process reforms that improve efficiency, accuracy, timeliness, and consistency; and proactively addressing culture change and training needs for staff. The lessons from these states suggest options that may bear examining and possibly adapting to the unique circumstances and traditions of the administration of eligibility in the New York Medicaid program.

Introduction

New York's Medicaid program provides health coverage to 4.1 million children, low-income adults, people with disabilities, and elderly adults. It accounted for \$44.7 billion in federal, state, and local spending on services in federal fiscal year (FFY) 2006 (Birnbaum 2008). It is the largest Medicaid program in the nation in terms of total cost, and second only to California in terms of the number of covered lives. New York is a national leader in terms of offering health coverage options for low-income uninsured children and families. A recent federal report shows that New York had the lowest rate of uninsurance for children among the twenty largest states (Cohen and Martinez 2007). Despite these efforts, however, it is estimated that 40 percent of New York's 2.4 million uninsured non-elderly residents are eligible for an existing publicly financed health insurance program (Cook, Miller, and Holahan 2007).

The New York Medicaid program, directed by the Office of Health Insurance Programs (OHIP) within the New York State Department of Health, is seeking to maximize the enrollment of low-income uninsured children and families into health coverage programs such as Medicaid for which they already qualify. OHIP has undertaken a wide-ranging examination of options for improving the performance of the state's Medicaid eligibility system, including a careful examination of policy reforms that might support increased coverage of eligible populations. OHIP is now also taking additional steps to ensure that eligibility policy is implemented effectively and consistently across the state.

In support of this initiative, the United Hospital Fund (the Fund) commissioned Health Management Associates, Inc. (HMA), a national health care research and consulting firm, to examine how states organize and administer eligibility processes for Medicaid. The purpose of this research was to understand how other states operate their state Medicaid eligibility systems, with a particular focus on initiatives states have undertaken to improve the performance of Medicaid eligibility processes, and to identify possible best practices or lessons learned that might inform New York's consideration of structural improvements.

Significance of Medicaid Eligibility Administration

The State Children's Health Insurance Program (SCHIP), enacted in 1997, included a statutory mandate for states to conduct outreach and to find and enroll eligible children without health insurance. This mandate triggered a renewed focus on enrolling low-income children in publicly financed health programs (whether through Medicaid or freestanding SCHIP programs). Since that time, there has been heightened attention paid to the policies that define eligibility for public health coverage programs.

More recently, governors have increasingly undertaken initiatives to reduce the numbers of uninsured working families,¹ which has focused even more attention on how states can improve the effectiveness of their Medicaid eligibility policies. Many states have modified income and asset standards and expanded the use of income disregards, or have implemented creative waiver strategies, to reach more low-income uninsured children and adults. Others have adopted presumptive eligibility options, allowed self-declaration of eligibility requirements, lengthened re-determination cycles, or even provided passive renewal or periods of guaranteed eligibility to simplify application and re-determination processes and improve retention and continuity of coverage. Some states have enacted premium support options to help workers afford employer-offered health benefits. Various policy options have been piloted, studied, debated, and promoted by policymakers, advocacy groups, and researchers (Smith et al. 2007).

Even the most carefully designed health program can fall short of achieving its intended goals, however, if it is not implemented effectively. A program designed to offer low- or no-cost health insurance coverage, for example, will serve few of its targeted uninsured population if applicants are frustrated by a burdensome application process that discourages or confuses. If the information technology systems and tools that support eligibility application and determination fail to work properly or quickly, the eligibility process will be plagued by delay, error, and inconsistency, exposing the state to negative audit findings and perhaps causing unnecessary denials of coverage. Eligibility expansions can be undermined by the day-to-day interactions between eligibility workers and applicants if workers are not trained, supported, and encouraged to effectively implement changes in state policies.

Nationally, relatively little attention has been paid to the mechanics of Medicaid eligibility, i.e., how administrative responsibility for various tasks is allocated, supported, monitored, or measured for effectiveness. Indeed, in undertaking this evaluation, HMA found almost nothing in the way of evaluations of different state approaches to the implementation of eligibility policy. There has been limited formal research into the most effective ways to organize and administer eligibility processes under Medicaid. Little is understood about the relationship between administrative design and the effectiveness of eligibility policy in terms of enrollment and retention of eligible populations, the accuracy of eligibility determinations, and the quality of service to eligible and enrolled persons. Data are scarce on important questions, such as:

- How does a state's application and enrollment process design affect its success? Is there a difference in outcomes or efficiency between centralized and decentralized approaches, between the use of state versus county eligibility workers, or between manual and automated processes?

¹ In 2007, a total of thirty-four governors proposed health coverage expansions or other strategies to reduce the number of persons without health insurance (National Association of State Budget Officers 2007).

- How do state Medicaid agencies interact with social service programs such as Temporary Assistance for Needy Families (TANF), child care, and Food Stamps, and how does that interaction affect Medicaid enrollment efficiency?
- What changes — both process and cultural/organizational — have had the most significant impact on enrollment and retention of eligible individuals in Medicaid? Most importantly, what did the states that achieved positive changes do to succeed?

Furthermore, a basic measure of effectiveness, the Medicaid participation rate (the percent of potentially eligible people, within an eligibility group, who are enrolled in Medicaid) is not available on a state-specific basis.²

Methodology

The goal of this project was to identify those administrative changes, undertaken in recent years in a number of states, which were considered most effective by Medicaid eligibility officials, to draw lessons and principles from the states' experiences that could inform New York's policy choices.

First, HMA reviewed current research on eligibility policy and interviewed national experts to obtain a broader understanding of the link between policy and operations in achieving improved enrollment outcomes. Then, in consultation with the Fund and the Office of Health Insurance Programs, HMA identified six states for in-depth review of eligibility administration processes: California, Florida, Kansas, Louisiana, Massachusetts, and Ohio. These represent a mix of large states, with correspondingly complex Medicaid programs, and smaller states that have undertaken significant Medicaid operational system redesign in recent years.

A detailed interview guide was developed to address issues of both eligibility administration and its perceived effectiveness, including:

- Administrative responsibilities for Medicaid eligibility determination:
 - Which agency is responsible for eligibility policy, the eligibility computer system, and the eligibility determination application and decision?
 - The role of other agencies and methods of coordination,
 - Roles played by outside vendors/contractors,
 - The source of administrative funds for eligibility determination;

² For a discussion of the data challenges in efforts to measure penetration rates for children in Medicaid and SCHIP see Kenney 2007.

- The Medicaid application and eligibility determination process:
 - Methods used (face-to-face, mail, telephone, Web), and whether they vary for different populations,
 - Centralized or decentralized application intake,
 - Separate application or combined with one for other social services programs,
 - Same or different application process than for SCHIP;
- Use of information technology systems to support Medicaid eligibility determination;
- Eligibility operational improvement initiatives undertaken by the state;
- Measures of effectiveness used by the state.

Interviews with New York Medicaid officials provided a baseline for evaluating responses from the six case study states. And the Office of Health Insurance Programs offered feedback that was used to finalize the guide (see Appendix), before HMA staff interviewed officials in each of the six case study states.

Literature Review, Available Data, and Interviews with National Experts

HMA undertook a review of available literature on effective approaches to the design and operation of Medicaid eligibility systems. The key finding was that very little literature exists on the subject. Although there is a body of literature on policies states have adopted to expand eligibility and to simplify eligibility processes and applications, no comparable work addressed issues of agency organization, operations, and the design of the Medicaid eligibility workflow. As a result, HMA chose to interview national experts who have conducted research on state eligibility policies.

Those interviews, as well as discussions with state officials, supported an intuitive relationship between successful eligibility policy reform and effective operational processes. Donna Cohen Ross of the Center on Budget and Policy Priorities, and Ian Hill of the Urban Institute, have both evaluated state Medicaid application policy changes, such as eliminating face-to-face interviews, reducing verification document requirements, and streamlining the re-determination process. They found that states achieved varying levels of success in increasing enrollment rates following adoption of these policies.

In some cases, hospitals and other providers were successfully integrated into the application process in a significant way (Cuyahoga County, Ohio is an example). On the other hand, as Hill related, when California eliminated face-to-face interviews, the need for follow-up contacts by eligibility case workers, to obtain documentation that was still required, increased significantly. The number of steps in an eligibility process (e.g., how many approvals are required, how many times an applicant can appeal a denial decision, how many different staff are involved in each determination, etc.), both researchers found, will affect the ability of a state to process applications in a timely and efficient manner, and the degree to which applicants follow through on all the steps to a complete application.^{3,4}

³ Telephone interview with Donna Cohen Ross, Center on Budget and Policy Priorities, July 2007.

⁴ Telephone interview with Ian Hill, Urban Institute, July 2007.

Interviews were also conducted with the Southern Institute on Children and Families, which runs the Eligibility Process Improvement Center (EPIC), whose mission is to assist states in implementing more effective eligibility systems for Medicaid and SCHIP. EPIC works with individual states, using “Plan-Do-Study-Act” learning modules, to understand current problems, conduct strategic planning around solving identified problems, study and conduct demonstrations of the resulting strategic plans, and implement those plans. According to the Institute’s Vicki Grant,⁵ a “high-quality” eligibility system would focus on:

- Enrolling and retaining eligible children and families;
- Providing good customer service and short application-processing times;
- Expanding and improving the state’s data capabilities through automated processes that allow for consistent decision-making across the state, eliminating variation from office to office; and, perhaps most instrumental,
- Effectively putting policy into practice.

A number of states have undertaken independent efforts to address specific Medicaid eligibility operational challenges. In general, though, the field lacks quantitative measures of system effectiveness. No data were found on measures such as timeliness, accuracy, and consistency of policy application; consumer satisfaction with the application/re-determination process; efficiency or cost per application; and penetration, or percent of potentially eligible individuals enrolled.

Another potential source of information was the Medicaid Eligibility Quality Control (MEQC) process, a long-standing federally required review by states to measure accuracy in eligibility administration. By 1994, all states had achieved error rates of less than three percent. Since then, Medicaid programs have been generating state-specific alternatives for measuring the quality of their eligibility processes. With thirty-one states having developed such MEQC “pilot programs,” measures are no longer uniform and it is difficult to compare performance across states.

The Improper Payments Information Act of 2002 enacted an additional quality control that elevated attention to Medicaid program accuracy. The Centers for Medicare & Medicaid Services (CMS) has implemented the Payment Error Rate Measurement program (PERM), using three national contractors to perform statistical calculations, medical records review, and medical/data processing review of selected state Medicaid and SCHIP fee-for-service and managed care claims. PERM also includes reviews of underlying eligibility determinations that are the responsibility of the states. In early 2008, CMS announced a preliminary Medicaid fee-for-service component error rate, based on the payment reviews conducted in the first seventeen states (for the first two quarters of FFY 2006 only). The initial payment error rate across the seventeen states was 18.5 percent; CMS did not release state-specific information (CMS 2007).

⁵ Telephone interview with Vicki C. Grant, PhD, MSW, Southern Institute on Children and Families, July 2007.

New York's Eligibility Structure

Administrative Structure

New York's eligibility system for Medicaid is large, complex, and highly decentralized. The "Single State Agency" for the program is the New York State Department of Health (DOH).⁶ Within DOH, the Office of Health Insurance Programs is primarily responsible for Medicaid program policy, including eligibility policy. The computer system that supports Medicaid eligibility in New York is maintained, however, by a separate state cabinet level agency, the Office of Temporary and Disability Assistance (OTDA). This system supports multiple health and social services programs, including New York's Temporary Assistance for Needy Families (TANF, or "cash assistance").

The application and determination process for Medicaid is the responsibility of fifty-eight local Departments of Social Services — fifty-seven county-based departments, plus one department representing the five boroughs of New York City. The local departments' eligibility workers use the OTDA computer system to support the eligibility determination process. Administrative funding is supplied by both state and county appropriations. In 2005, the New York State legislature capped county Medicaid-related costs, with the state assuming responsibility for all costs in excess of the cap (including new administrative costs). The Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities, both located outside the Department of Health, can also process applications directly for their eligible beneficiaries.

DOH contracts with two private firms that are required to interface with the statewide eligibility computer system. One contractor serves as the managed care enrollment broker in New York City, Long Island, Westchester, and ten additional counties; the other is contracted to manage eMedNY, the Medicaid claims payment system.

Application and Eligibility Determination Process

The Medicaid application process is heavily influenced by state eligibility policy, federal eligibility requirements, the state's use of information technology, and the administrative structure adopted by each state. In New York, all Medicaid applications are taken (or sent to) and processed in a local Department of Social Services office. The Medicaid application is a combined form that includes information to determine eligibility for TANF, Food Stamps, Medicaid, SCHIP, and other services, including foster care and child care assistance. In addition, a separate application can be used to apply for health insurance programs

(Medicaid, Family Health Plus, or Child Health Plus) alone. A face-to-face interview is required for all initial applications. New York offers a presumptive eligibility process for pregnant women.

New York trains community-based organizations to assist with completing applications for “community” Medicaid (for children, parents, and non-elderly adults). Community-based “facilitated enrollers” can conduct face-to-face interviews and transmit completed applications to their local Department of Social Services on behalf of applicants. Applications for elderly and disabled persons must be taken directly by local Department of Social Services staff.

Medicaid eligibility renewals can be submitted by mail for all categories of eligibility; since January 2008, self-declaration of income at renewal is allowed for most beneficiaries. In addition, New York is piloting the use of two electronic applications by enrollment workers; one is being phased in for use by local Department of Social Services staff, and the other is being developed to assist community-based facilitated enrollers.

In contrast to the Medicaid application process, New York’s SCHIP application is not county-based. Instead, applications are accepted through the SCHIP-contracting managed care plans, with a centralized computer system used to determine eligibility.

The Use of Information Technology

With the exception of piloting electronic applications for use by eligibility workers, as noted above, New York has not implemented any significant changes, recently, in information technology supports for the eligibility determination process (e.g., Web-enabled submission of applications). Local Department of Social Services eligibility workers access the state’s eligibility computer system to manually input application and determination information. Changes to the computer system implemented by the Office of Temporary and Disability Assistance generate written notices to district commissioners, program managers, and technical staff, and state staff offer training to local Department of Social Services staff on how to implement any system changes.

Given the current decentralized administration of the eligibility system, giving priority to the resolution of Medicaid eligibility processing issues has been difficult. According to OHIP, use of a combined application and the fact that the system is maintained in a separate state department can result in significantly competing priorities regarding system upgrades and maintenance.

Operational Improvements and Accountability

New York's Medicaid program is seeking to increase statewide consistency in eligibility processing while maximizing enrollment penetration within eligible groups. OHIP reports that recent efforts have focused on policy reforms to simplify eligibility processes and requirements, including self-declaration of income and residency at renewal, and presumptive eligibility for children. New York has also enacted twelve months of continuous eligibility for adults, but implementation has been delayed due to difficulty securing CMS approval.

Training is currently a major tool for seeking statewide consistency in applying policy. The Department of Health administers the Medicaid Training Institute, and all local districts, health plans, and facilitated enrollers receive training at least once a year. The Department also provides training four to six times a year through regional consortium meetings. In addition, the state plans to transfer Medicaid Eligibility Quality Control reviews from the Office of Temporary and Disability Assistance to the Department, which believes these quality reviews will be an effective tool for monitoring implementation of policy changes throughout the eligibility system.

New York Medicaid officials remain concerned, however, that inconsistency in policy implementation might occur (or continue to occur) at the local level. This raises issues of process quality as well as concerns that local inconsistencies may contribute to a perceived failure to maximize current enrollment. Staff also acknowledge that current computer system supports are not state of the art and may contribute to current challenges.

Eligibility Administration in Selected States

Administrative Structure

State administrative structures used for putting Medicaid eligibility policy into operation vary widely, often heavily influenced by the history of each state's health and human services system development, the state's traditional division of labor between state and local government entities in the human services arena, and how the state finances Medicaid administrative activities.

These influences can be seen in the experiences of the six case study states. In some, including California, Florida, and Ohio, the current administrative structure continues to reflect the historical relationship between Medicaid and the cash assistance program. Here, state or county agencies responsible for TANF retain primary responsibility for processing

Medicaid eligibility, more than a decade after reforms severed the formal federal link between Medicaid and cash assistance. This approach may also reflect a commitment to a shared application process that facilitates exploration of all potential health and social services benefits for which an individual might qualify.

Other states, including Massachusetts, Louisiana, and Kansas, have undertaken reforms that place increased responsibility for eligibility processing on the Medicaid program itself. Oversight for Medicaid eligibility — policy, computer system support, and processing — remains within the Medicaid agency, rather than being maintained by or shared with the state’s social services agency. In addition, the place or method of applying for Medicaid may be separated from the application process for cash assistance, Food Stamps, or other programs, and may include a “simplified” application process. These states appear to be focused on reducing the number of uninsured individuals by maximizing enrollment of eligible populations, although some have used technology to facilitate eligibility consideration for other programs as well.

Almost all of the case study states report use of private vendors to support some aspect of eligibility processing and/or administrative support functions that must interface with the eligibility structure. Most often, states use private firms to provide eligibility or Medicaid Management Information System computer support, as well as for enrollment broker services for Medicaid managed care.

California. California’s Single State Agency for Medicaid is the California Department of Health Care Services (CDHCS), which is housed in an umbrella health and human services agency that also includes the California Department of Public Health, California Department of Social Services, California Managed Risk Medical Insurance Board, and other state departments. Unlike New York’s structure, where the eligibility computer system is managed by a separate cabinet agency, CDHCS is responsible for both Medi-Cal (California’s Medicaid program) eligibility policy and the state-level eligibility computer system.

As in New York, the actual processing of Medi-Cal eligibility is the responsibility of county “welfare offices.” In fact, the fifty-eight California county departments of social services (which go by a variety of names) make the eligibility determination using one of four county-contracted eligibility computer systems. County systems then upload the information to the statewide computer system at CDHCS. The state provides guidance regarding eligibility determination policies, but counties have considerable discretion regarding the process. Administrative funding for Medi-Cal eligibility determination is provided by the state, with allocations to counties.

Another department, the Managed Risk Medical Insurance Board, contracts with a private vendor to support a “Single Point of Entry” for SCHIP and any electronically submitted Medi-Cal applications. The four county-contracted eligibility computer systems are also provided by private vendors.

Florida. Florida’s Single State Agency is the Agency for Health Care Administration, a free-standing unit responsible for a variety of Florida health programs, including Medicaid eligibility policy. It is the separate Department of Children and Families (DCF), however, that is responsible for the state’s highly automated eligibility computer system, ACCESS Florida, which supports multiple social program applications. Other state agencies have specific roles in the eligibility process, as well: the Florida Department of Health determines medical eligibility for children with special health care needs, and those determinations are forwarded to DCF for entry into ACCESS. Unlike the case in New York and California, county governments do not have direct responsibility for Medicaid eligibility processing.

Administrative funding for Medicaid eligibility processing is provided by the state, although several counties also choose to provide funding for community partner activities (described in the next section of this report). Private vendors play central roles in Florida’s eligibility system: one is under contract with DCF to maintain the ACCESS Florida computer system, while another is under DCF contract to perform PERM-related activities. The Agency for Health Care Administration also contracts with private firms for Medicaid Management Information System services and for Medicaid managed care choice counseling and enrollment broker services.

Ohio. Ohio’s Single State Agency is the Ohio Department of Job and Family Services (ODJFS), which administers the state’s traditional human services programs, health programs including Medicaid and SCHIP, and the state’s employment services programs. Within the Department, primary responsibility for Medicaid eligibility policy rests with the Office of Ohio Health Plans; the Medicaid program’s eligibility computer system is shared with other social programs, and is managed by a centralized information systems office within ODJFS.

Medicaid application intake and processing is the responsibility of Ohio’s eighty-eight county departments of job and family services. County eligibility workers use the state’s eligibility computer system, which makes final determinations. County workers are required to adhere to rules promulgated at the state level, but county offices have discretion in establishing

internal operational procedures related to those rules. For example, some counties establish specialized units by program, while others use generalist workers to process applications for all programs. Counties also have some discretion regarding the kinds of documents acceptable for satisfying income documentation requirements.

Other state agencies with specific responsibility in the eligibility process include the Ohio Department of Mental Retardation and Developmental Disabilities, which coordinates level-of-care determinations for certain waiver programs. Private vendors are more tangential to the eligibility system: ODJFS contracts with one vendor to provide customer information services, including a telephone hotline and managed care enrollment broker support, while another private firm is under contract to develop (but not operate) a new Medicaid Management Information System. Administrative funding for Medicaid eligibility is shared by both the state and counties.

Massachusetts. The Massachusetts Single State Agency is the Department of Health and Human Services, Office of Medicaid. The Office is responsible for eligibility policy for MassHealth (which includes the state's Medicaid and SCHIP programs), all enrollment processes, and the computer system that supports eligibility. Processing related to all state-supported health care programs is managed through four regional state-operated MassHealth Enrollment Centers and a central processing unit at MassHealth Operations in the Office of Medicaid — there is no county responsibility for eligibility. All administrative funding is provided by the state.

Other state agencies, specifically the Office of Social Security, Office of Youth Services, and Office of Mental Retardation, have some responsibility for certain MassHealth programs and report to the Office of Medicaid on these activities. A private vendor is under contract with the Office of Medicaid to provide enrollment broker services for MassHealth managed care plans and to collect any premiums, enrollment fees, or other up-front cost-sharing.

Louisiana. Louisiana's Single State Agency is the Department of Health and Hospitals, Bureau of Health Services Financing, which is responsible for eligibility policy as well as for the eligibility computer system. Responsibility for Medicaid eligibility was transferred to the Department from the cash assistance program in 1992.

With one exception, the Department of Health and Hospitals is responsible for all eligibility processing for Medicaid, although it contracts with private physicians to review clinical information and make decisions on disability-related applications. Another state agency, the

Administrative Organization: Case Study States and New York

State	Enrollment as of June 2006 (in millions)	Medicaid agency maintains eligibility IT system?	Eligibility workers	Administrative funding
New York	4.2	No	County	State and county
California	6.4	Yes ^a	County	State
Florida	2.2	No	State	State
Kansas ^b	0.3	No/Yes	State	State
Louisiana	1.0	Yes	State	State
Massachusetts	1.0	Yes	State	State
Ohio	1.6	Yes ^c	County	State and county

^a California counties contract with one of four eligibility IT systems, which transmit data to the state's single eligibility IT system, managed by the California Department of Health Care Services.

^b Kansas is in the process of moving responsibility for eligibility operations to the Kansas Health Policy Authority, newly reorganized with responsibility for coordinating all state health programs.

^c Ohio's IT system is managed within the same department but in a separate unit from the Office of Ohio Health Plans.

Department of Social Services, determines eligibility for children in foster care (as well as eligibility for TANF). As in Massachusetts, there is no county responsibility for Medicaid eligibility. The University of New Orleans provides the Department of Health and Hospitals with software development, hardware support, and tech support for the statewide eligibility computer network. All administrative funding is provided by the state.

Kansas. The Kansas Single State Agency is the Kansas Health Policy Authority, created in 2005 to consolidate all state health care purchasing in a single agency, led by a board appointed by the Governor. The Authority is responsible for eligibility policy for the Kansas Medical Assistance Program (the state's Medicaid program). At the time of the HMA interview, another state agency, the Department of Social and Rehabilitative Services, was responsible for the eligibility computer system that is shared with other social programs. Kansas is in the process of moving responsibility for IT support for Medicaid eligibility to the Health Policy Authority.

Responsibility for application intake and processing is also in transition. Currently, Kansas relies on Department of Social and Rehabilitative Services staff in regional offices to assist Medicaid applicants, with most applications then processed through a Health Policy Authority Central Clearinghouse (a private vendor is under contract to support the Clearinghouse). With responsibilities of the state agencies being realigned, the Authority is slated to take over all responsibility for eligibility and enrollment. There is no county responsibility for Medicaid eligibility. All administrative funding is provided by the state.

Application and Eligibility Determination Process

While HMA found considerable variation across states in intake and eligibility determination processes, there were some strong similarities in the Medicaid application process. In most states, for example, even where the TANF agency is no longer responsible for overseeing Medicaid eligibility processing, the application for Medicaid is part of a combined application form that can be used to apply for a range of social services (most commonly Food Stamps and TANF). Examples include the systems in Florida, Kansas, Massachusetts, Louisiana, and Ohio. California and Massachusetts offer access to a range of state-supported health coverage programs through a single application.

But even those states, including Ohio, Kansas, and Louisiana, that have a combined application for Medicaid and social services programs often offer more targeted, health-care-only application options. Some states, including Louisiana and Kansas, offer or plan to offer separate application systems for health coverage and for social services supports. Massachusetts also offers a health care “front door,” although its IT system accommodates applications for social services programs as well.

Several of the case study states have modified eligibility policies to streamline or simplify the process, sometimes reducing reliance on face-to-face interviews (California, Ohio, Florida, and Massachusetts), providing electronic filing options for applicants (Florida), or, as in New York, simplifying renewals (Massachusetts). Like New York, California and Florida have an application process for SCHIP that is different than the process used for Medicaid.

All of the case study states have some sort of regional or local process for application intake and/or assistance. Most of the states, including Florida, California, Massachusetts, and Louisiana, provide a fairly robust system of community-level “assisters,” in addition to county or state eligibility workers, to enhance outreach and support for consumers. Ohio and Kansas do not offer organized community assistance supports, but Ohio reported that counties could, at their option, place workers at provider sites or work with community organizations on outreach initiatives, and Kansas reports that some eligibility workers rotate through similarly “out-stationed” hospital settings.

California. California’s application process is perhaps the most decentralized and varied of the case study states, at least in terms of consumer options for filing an application. County departments process eligibility, and the state reports that, although a face-to-face interview is no longer required, the “vast majority” of applications are made in person at the fifty-eight county social services offices. County eligibility staff in these offices work with applicants (and, at renewal, with beneficiaries) to obtain all necessary information and documentation. The eligibility information is entered into one of the four computer systems used by counties in conducting the eligibility determination process. Eligibility determination information is then uploaded to the state’s Medi-Cal eligibility data system.

Other filing options include the Single Point of Entry, a central intake center maintained by the state's Managed Risk Medical Insurance Board that processes all applications for Healthy Families (California's SCHIP program). The Single Point of Entry also accepts joint Medi-Cal/Healthy Families applications. In addition, thirty-four of California's counties offer a combined paper application for Cash Aid, Food Stamps, Medi-Cal, and county-run Indigent Programs.

Along with county eligibility staff, California's Certified Application Assistants (CAAs) — employed by local, non-profit organizations or agencies — help with public program outreach and enrollment. The state offers an electronic joint application for Medi-Cal and Healthy Families, called the Health-e-App, which can only be filed by CAAs. A second electronic application, the so-called "One-e-App," designed to explore eligibility for all publicly funded health care programs (state- and county-specific), is being piloted in nine counties for use by CAAs and some local school districts. One-e-App is not administered by the state, although the state is working collaboratively with the counties and the non-profit organization that maintains the software. However received, all Medi-Cal applications are transferred to the applicant's county of residence for processing. California does not offer electronic versions of county-specific combined (cash/Food Stamps/Medi-Cal/Indigent Program) applications, although One-e-App might be expanded in the future to include the social services programs in addition to health care.

Florida. Of all the case study states, Florida offers the most automated application process. The state's social services agency, rather than the Medicaid agency, processes Medicaid applications. Florida redesigned its application process for Medicaid and other public assistance programs to provide and encourage consumers to use an on-line application. The ACCESS Florida system can be used through any computer with Internet access, and applications and re-determinations can be filed around the clock, seven days a week. The state operates regional call centers (Automated ACCESS Response Units) through the Department of Children and Families, and relies on over 3,000 "community partners" to provide local assistance to consumers. Community partners include aging resource centers, child advocacy centers, county public health departments, faith-based organizations, food banks, hospitals, libraries, homeless organizations, schools, WorkForce One Stops, and other local social services agencies. No face-to-face interviews are required.

ACCESS community network partners provide varying levels of support for applicants: "partner sites" offer simple availability of paper applications; "bronze sites" provide consumer access to computers and telephones to support submission of applications online; "silver sites" offer computer, telephone, and printer access; "gold sites" provide access to fax machines and copiers, in addition to computers, to assist in submitting required documentation; and "platinum sites" provide full service, including in-person assistance.

Ohio. Ohio offers a decentralized application process, in which almost all applications for Medicaid are received and processed by eighty-eight county departments of job and family services, using a centralized, state-managed eligibility IT system. Counties may operate more than one office site within a county. The state uses a common, paper application for Medicaid and public assistance programs. A second, shorter application is available for pregnant women and children applying for coverage through the state's Medicaid expansion program, HealthyStart (which includes the SCHIP program). The state also offers a limited form of presumptive eligibility for pregnant women, called "expedited eligibility," which provides outpatient services for a limited period while full eligibility is being determined.

Face-to-face interviews are required only for applicants in aged, blind, and disabled categories. Applications for Medicaid coverage for parents and children can be filed in person or through the mail. The state has not implemented any form of passive renewal, but some counties choose to send out partially completed applications at eligibility re-determination.

Massachusetts. Massachusetts has adopted a Virtual Gateway strategy to create a one-stop application process for a wide array of state-supported health coverage programs. All health care program applications, including those for Medicaid, are processed by the MassHealth program. An applicant for health coverage who is under the age of 65 can call one of four regional MassHealth Enrollment Centers to obtain a Medical Benefits Request form. The applicant returns the paper application by mail to the center, and the information is typed into the Virtual Gateway computer system, forwarded electronically to the "back-end" system, called the MA 21, and processed for an eligibility decision. Alternatively, an applicant may go in person to one of the 140 hospitals or community health centers that have access to the Virtual Gateway, and have a staff person input application information directly into the system. The single application process allows eligibility determinations for all state-supported health care programs. The state reports that 60 percent of applications begin at one of the community provider sites, while 40 percent are mailed in by applicants.

Applicants age 65 or older receive a Senior Medical Benefits Request form and are assigned a state staff person who determines eligibility on a case-by-case basis, without using the Virtual Gateway.

While the focus of the application process appears to be health care, the MA 21 actually creates three applications, based on an individual's information: one goes to MassHealth, one goes to the state's child care agency, and one goes to the state's Food Stamp agency. Eligibility for child care and food stamps is determined by the respective program office, using the data submitted through the Virtual Gateway. State officials report that 98 percent of the volume of applications processed through the Virtual Gateway is directed toward MassHealth, however, rather than the social services programs.

Application and Eligibility Processes: Case Study States and New York

State	Application intake locations	Community assistance organizations?	Combined application?	Mail-in, telephone, or online options?	Same process for SCHIP?
New York	County	Facilitated enrollers	Yes	NA	No
California	County	Certified Application Assistants, limited outstationed eligibility workers at hospital clinics	Yes ^a	Mail ^b	No
Florida	Regional ^c	Extensive network of community partner sites	Yes	Mail, telephone; ^d online preferred	No
Kansas	Regional	Some out-stationing in hospitals	Yes ^e	Mail, telephone	Yes
Louisiana	County ^f	Community organizations contract to assist	No ^g	Mail	Yes
Massachusetts	Regional	Hospital, health center staff trained to assist	Yes ^h	Mail, telephone	Yes
Ohio	County	County option	Yes ⁱ	Mail	Yes

^a California has combined the application for SCHIP (Healthy Families) and Medicaid (Medi-Cal) for children and pregnant women. This joint application is available on paper and electronically. California also has a combined application for Medi-Cal and social services programs. In addition, nine counties use an electronic application (the One-e-App) to screen applicants and submit applications for multiple health programs.

^b Health-e-App, the online Medi-Cal application, is available through the Single Point of Entry administered through the Managed Risk Medical Insurance Board for certain Medi-Cal populations. As noted above, some counties also use the electronic One-e-App for applications to multiple programs, including Medi-Cal. Neither of these applications is publicly accessible, however; only Certified Application Assistants can submit applications via Health-e-App and One-e-App.

^c Florida has state eligibility workers located in regional offices administered by the Department of Children and Families, supplemented with a wide array of community partner sites with varying availability of application tools and assistance.

^d Only 0.1 percent of applications are received by telephone.

^e Most applicants do not use the combined application form, although it is available.

^f Nine regional administrators oversee local (parish) offices.

^g People who apply for TANF, however, can also apply for Medicaid on the same form.

^h Massachusetts' IT system creates duplicates, which may be separately processed for social services programs, from a single application.

ⁱ Ohio also offers a simplified "Medicaid-only" application for pregnant women and children.

Massachusetts uses a "profiling system" of passive renewal. Enrollees who applied with a Medical Benefits Request form receive a review form sent automatically by the eligibility system; they have sixty days in which to complete the form and return any necessary verification. There is then no follow-up contact for one year.

Louisiana. Louisiana's Department of Health and Hospitals operates forty-five parish-based enrollment offices and nine regional enrollment offices. Applicants have multiple entry points available, but all staff use one electronic system. Paper applications can be mailed to either the central office in Baton Rouge or to a local parish office. All data are entered into the computer to create an electronic record; paper verifications are scanned into the record. All eligibility staff have access to any electronic application record, statewide. LaChip, Louisiana's SCHIP program, uses the same eligibility process.

People applying for TANF can apply for Medicaid through a combined application. However, the state's Medicaid Application Centers also offer forms tailored to specific programs (e.g., waiver programs, LaCHIP, LaMoms, and the Breast and Cervical Cancer and Working People with Disabilities programs) if applicants are not interested in other forms of assistance.

Along with offering parish-based state eligibility offices, Louisiana contracts with community organizations to perform outreach and assist applicants.

Kansas. Kansas is currently moving eligibility processing from the state social services department to the newly organized Kansas Health Policy Authority. Today, individuals can apply for Medicaid in Kansas by telephone, by mail, or in person at one of forty-two local service centers operated by the Department of Social and Rehabilitative Services. The Department's eligibility staff specialize in TANF or programs for the aged, blind, or disabled, to provide situation-specific assistance to applicants. Some state staff rotate through hospital settings. More than 85 percent of applications are processed by the Central Clearinghouse operated by the Kansas Health Policy Authority.

Kansas offers a combined application for Medicaid, SCHIP, and public assistance programs; Department of Social and Rehabilitative Services centers run a combined eligibility computer system. Most Medicaid and SCHIP applicants, however, use a form tailored to a specific health care eligibility category. The state offers a simplified form for TANF/SCHIP.

The Use of Information Technology

With the notable exception of California, the case study states use a centralized computer system to support eligibility processing. In most cases, eligibility workers enter application information obtained from consumers (directly or from paper application forms); in Florida, applicants can apply electronically themselves, through the Internet.

It is clear that IT enhancements have played a key role in state efforts to improve eligibility processes in recent years. Florida, Louisiana, and Massachusetts have made extensive use of enhanced information technology to facilitate operation of their eligibility systems, and Kansas is planning to use information technology to support a major reform of Medicaid eligibility processing. It is important to note that IT solutions do not stand alone in these states, but were introduced as a critical tool to enable workflow and policy reforms that were designed to improve system performance. States uniformly report improved quality and consistency with these reforms. In addition, some states reported that automated solutions have allowed states to handle increased caseloads with relatively small or reduced numbers of eligibility workers.

While California struggles with working through multiple local computer systems, the state is turning to automated options to better coordinate its decentralized system and support increased enrollment in target groups, especially children. Ohio cites its outdated eligibility computer system as the major barrier to more effective and consistent eligibility processes and, like Kansas, believes obtaining a replacement system is critical to future performance improvements.

Florida. Florida reports that implementation of the ACCESS Florida system, which is built around an electronic application process, is the most significant eligibility reform in the state in recent years. Of all the case study states, Florida is the only one that offers — and, in fact, encourages and facilitates the use of — an online application. Its IT reforms have allowed Florida to handle a dramatic reduction in state eligibility staff (the Department of Children and Families workforce was cut by about 40 percent, from 7,000 to 4,100).

Florida officials stressed that the eligibility system reforms went beyond IT improvements, however. The initiative included development of community partner sites to increase customer access to the newly automated application, as well as simplification of eligibility policies and procedures.

Louisiana. Louisiana has used IT enhancements to facilitate a more efficient and effective eligibility process, eliminating paper case records for financial eligibility. Images of applications, renewal forms, and any other data traditionally maintained in paper case records are now scanned at local offices. Medicaid application centers can submit electronic applications that can be imported directly into the Medicaid financial eligibility case record without a paper copy ever being printed. The sending of any notice or correspondence automatically generates a copy for the electronic case record and triggers an entry in the case activity log. Records are accessible electronically by all eligibility workers, at all locations. This improved IT has supported efforts to redesign policy and operations to improve customer service.

Louisiana plans to create an online application that can be used by consumers, but has yet to resolve related issues, including the need for a hard-copy signature.

Massachusetts. Massachusetts implemented its major IT system improvement in 2003-2004, with the introduction of the Virtual Gateway. In an effort to control the quality and accuracy of application information, the use of electronic applications is restricted to eligibility workers in the regional enrollment centers and in community health centers. The Virtual Gateway operates through a decision-tree logic system, so that applications cannot be processed without all the necessary information being input. The system takes decision-making out of the hands of eligibility staff, which the state reports has cut down on the error rate in eligibility determinations. In addition, the IT system allows Massachusetts to cover over one million beneficiaries with a small field staff of 305 eligibility workers.

The state's back-end system is also used to create a quasi-combined application that can be processed for all state-supported health programs as well as for child care and Food Stamp eligibility. The state is considering establishing a system through which individuals can establish an account to eliminate duplicate applications and other error-causing scenarios, allowing consumers to submit electronic applications directly.

Kansas. Kansas is reengineering its Medicaid eligibility and enrollment processes within the context of its broader health care program reform. As responsibility for the eligibility process is being shifted to the Kansas Health Policy Authority, the Authority's first priority is to procure a new computer system to replace the old system operated by the state's Department of Social and Rehabilitative Services. The goal of the new system will be to use state-of-the-art enrollment and eligibility information technology to increase the take-up rate of Medicaid-eligible beneficiaries. The system will incorporate Web-based functionality to accept applications, share documentation, and review files electronically. The Health Policy Authority is seeking funding for the new system and is optimistic about moving forward within the next three years.

California. California is piloting electronic application transmission by community application assistants. The Single Point of Entry, created to support paper and electronic SCHIP applications, provides a framework for expanding these efforts over time. The state has also implemented an automated process, known as the CHDP (Child Health and Disability Prevention) Gateway, to identify and pre-enroll children into Temporary Medi-Cal pending determination of eligibility for Medi-Cal or Healthy Families.

California officials noted that IT issues can create challenges as well as breakthroughs in system efficiency. Officials reported that the use of multiple eligibility processing systems by counties makes consistent implementation of policy and/or programmatic changes more difficult, and often adds time to the implementation process, depending on the programming requirements of each system.

Ohio. Ohio reported major concerns regarding the computer system supporting its Medicaid eligibility determination. Officials described the system as "aging" and "in dire need of replacement." It is difficult and time-consuming to modify, however, with added complexity stemming from the need to support multiple program eligibility standards. These IT inadequacies result in county eligibility workers having to process multiple manual "work-arounds," and increase problems with inconsistent implementation of policy. Ohio is in the process of replacing an outdated legacy Medicaid Management Information System, and has initiated a planning process toward future replacement of the eligibility IT system as well. In particular, the state would like to see Web-based capabilities, to make electronic application submissions possible.

Operational Improvements and Accountability

Each of the case study states described initiatives to improve the operation and effectiveness of its eligibility system. The most common goal of operational improvement was to increase penetration rates by insuring more of the potentially eligible population. Most states also focused on increased consistency, and a reduction in processing errors, within the application process. Improved efficiency was also a goal of some reforms. Reported strategies include:

Goal: Increased enrollment/penetration

- Placing eligibility processing under control of the Medicaid agency;
- Providing a “front door” focused on health care rather than on general social services;
- Use of trained, organized community-based application facilitators;
- Policy reforms to simplify the process (e.g., eliminate face-to-face interviews, allow self-declaration of certain requirements);
- Increased intake points for applicants, including adding telephone, mail, and online options;
- A change in “culture” for eligibility workers.

Policy reforms to simplify the eligibility process were common across states, and most states placed significant emphasis on the role of non-governmental, community-based organizations and sites in both outreach and assistance to applicants. Only one of the case study states, Florida, has implemented an online application option for consumers, but others reported significant interest in doing so. The most dramatic strategy, seen in Louisiana, Massachusetts, and Kansas, was to make the state Medicaid program fully responsible for the eligibility process, resulting in an application “front door” that placed a primary focus on health care coverage, rather than a general focus on social services. As demonstrated in Massachusetts, such a move can still accommodate a “one-stop” approach to applying for multiple health and social services programs.

Goal: Increased consistency/reduced error rates

- Use of information technology modifications to reduce individual decision-making;
- Regionalizing or centralizing staff;
- Re-engineering workflows and clarifying staff responsibility;
- Use of performance measurements tied to financial incentives;
- Outcomes-based contracting;
- Training;
- Engagement of eligibility staff in ongoing process improvement;
- Increased oversight of accuracy by Medicaid program staff.

Clearly, improved information technology systems were key to the most significant improvements in consistency of eligibility processing. Yet all states that had implemented — or planned to implement — new systems support also emphasized the importance of redesigning workflows and underlying eligibility policies to achieve improved results.

With or without technology reforms, states relied on training for improved outcomes. Massachusetts, for example, stressed the use of “frequent and intense” training for state workers and for community provider sites. Some states, especially Louisiana and Ohio, reported success with engaging eligibility staff in ongoing operational improvement initiatives. States, most notably California, Louisiana, and Florida, also described the important role that performance goals and performance measurement played in achieving improved outcomes.

Goal: Improved efficiency

- Automation of eligibility processes;
- Re-engineering workflows to reduce duplication and inefficiencies;
- Paperless sharing of documents;
- Use of online applications;
- Policy reforms to streamline processes.

Again, automation and the use of information technology to support redesigned workflows and simplified eligibility policy was the centerpiece of reported improvements in process efficiency. Florida and Massachusetts, especially, reported dramatically increased productivity as a result of enhanced IT strategies.

California. California has leveraged state financing for county Medicaid administrative costs to hold counties accountable for processing accuracy and timeliness. In 2003, the Governor submitted a budget proposal that called for the restoration of annual cost increases to the counties for administration, with the requirement that counties perform eligibility determinations and annual re-determinations in a timely manner.

The Department of Health Care Services, with the collaboration of the County Welfare Directors’ Association, established formal reporting cycles for the twenty-five largest counties (which represent 95 percent of the state’s Medi-Cal caseload). These counties report against performance standards on a two-year cycle. Counties that fail to meet standards in one year are given corrective action plans and required to report in the following year. Counties that fail to improve performance can be penalized up to two percent of their annual Medi-Cal administrative allocation for the following year. Performance standards specify that:

- 90 percent of general applications must be complete, without errors, within forty-five days (or within ninety days for applications based on disability);
- 90 percent of annual re-determinations must be begun by each applicant’s anniversary date, and 90 percent must be completed within sixty days of the annual re-determination date.

The performance measurement system helped reduce the state's Medicaid Eligibility Quality Control error rate from 8 percent to 6 percent in the last base period, the Department reports, despite counties experiencing increases in worker caseloads, policy changes, and changes to the multiple information systems.

The Department of Health Care Services coordinates with county welfare departments, the County Welfare Directors' Association, and others on the development of guidelines for county implementation of eligibility policy and requirements. Eligibility worker training is generally the responsibility of the local agencies, however, with in-service and other training provided by individual county departments and by the Directors' Association. In an effort to promote consistency and collaboration, there is a focus on sharing best practices between and among counties.

The Department reports that the strongly decentralized approach to eligibility processing in California results in some inconsistency across the state, a problem that is complicated by the use of multiple eligibility computer systems. Performance standards, supported by routine reporting and financial incentives, help reduce inconsistency. At the same time, the state Medicaid agency reports a level of comfort with local differences, believing that in a large and complex state like California, allowing practices that reflect local differences can have its advantages. For example, some counties have been very creative and energetic in funding and implementing initiatives that promote enrollment of children in the full range of state-supported coverage programs.

To increase enrollment, California encourages counties to initiate local outreach initiatives, supports the use of Community Application Assistants, has eliminated the requirement for face-to-face interviews, offers multiple options for submitting applications, and is working to accommodate increased use of electronic applications by application assistants. California has focused these efforts in particular on increasing enrollment of children in Medicaid, SCHIP, and other state- or county-funded programs.

Florida. As noted above, Florida views the development of ACCESS Florida as its most significant operational improvement initiative for Medicaid. Reorganized workflows, simplified application policies (no requirement for face-to-face interviews, for example), and a reliance on consumer submission of Internet-based electronic applications have dramatically reduced inconsistencies between counties and between the determinations made by individual workers. Re-engineering workflows was critical to standardizing procedures, stressed the Department of Children and Families. The state regionalized call center staff and clarified their responsibilities vis-à-vis the responsibilities of staff in the remaining local customer service centers, resulting in statewide, uniform procedures. IT system changes were then designed to support the reformed workflow.

According to the Department's monthly release of "Critical Few Performance Measures" for August 2007, a report designed to reflect progress in implementing the ACCESS program:

- More than 98 percent of all applications are processed within Standard of Promptness timeframes, and
- More than 90 percent of all applications are completed by use of automation.

Automation and reengineering have also resulted in a significant increase in productivity among a dramatically reduced eligibility workforce. At the same time, the state has encouraged establishment of a broad and varied array of community-organized application assistance sites to reach consumers and facilitate applications.

Those innovations have led to recognition by leadership at the federal Agency for Health Care Administration. ACCESS Florida was named a 2007 winner of the Innovations in American Government Award by the Ash Institute for Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government, and the \$100,000 prize allowed the Department of Children and Families to advise other government organizations in replication of its successes.

The Department is responsible for training staff in local resource centers and for training community partners, using both in-person training ("train the trainers") and video conferencing. The Department regularly schedules meetings with staff at the state's Agency for Health Care Administration, as well, to address system interfaces as well as Medicaid-specific policies or initiatives.

[Kansas](#). In Kansas, only the Central Clearinghouse, managed by the Kansas Health Policy Authority, is currently capable of sophisticated performance reporting, interviewed officials noted. Difficulties with accessing performance data in the current regional system, managed by the Department of Social and Rehabilitative Services, make for variations across Department offices and between those offices and the Clearinghouse. The Authority and the Department are currently working on an interagency agreement to establish outcome processes and move to outcome-based contractual relationships with staff.

The Health Policy Authority believes that shared responsibility for eligibility, as well as outdated computer systems, are major weaknesses of the current eligibility process. With increased enrollment penetration a major goal, performance reporting will be a feature of the eligibility system that the Authority plans to develop, as the full responsibility for Medicaid eligibility shifts to it. Additional performance improvement goals include reduced consumer "hassle" and a lower cost per enrollment.

Louisiana. Louisiana reports that the automation and re-engineering of its eligibility process has resulted in increased accuracy and reduced costs for the system. Beyond automation, the state has undertaken major performance improvement through an initiative called *WorkSmart!* The effort was created by the Louisiana Eligibility Process Improvement Collaborative, which involved twenty local eligibility offices and addressed policy, procedures, training, operations, customer service, application processing times, and retention rates. The Southern Institute on Children and Families provided technical support in the initiative's first year.

The initial focus of *WorkSmart!* was on lowering case closure rates. Eligibility offices implemented procedural changes that included follow-up phone calls to families whose children were at risk of being dropped from coverage at re-determination, and a new requirement of supervisory authorization before the closing of any case. Louisiana reports that the focus of *WorkSmart!* is as much on reforming the "culture" of the eligibility offices as it is on reforming procedures and policy. Eligibility staff are encouraged to pursue quality in process with "risk-taking single-mindedness." This approach has led to dramatic improvements, including a reduction in procedural closures for children's cases from a high of 62 percent to an impressive 1.25 percent.

Multiple performance reports are required from the nine regional state offices, including:

- Number of procedural closures;
- Application processing times (by population);
- Local office workflow; and
- Quality measures and renewal outcomes.

Louisiana's Medicaid program leadership is enthusiastically supportive of this approach to eligibility oversight and program improvement initiatives. The state reports that its new IT system supports ongoing staff training on policy and procedural changes. All eligibility employees receive policy alerts and revisions online. In addition, a Medicaid Eligibility Internet portal contains news, alerts, clarifications, and links of interest to eligibility workers.

Massachusetts. Massachusetts views its Virtual Gateway approach to eligibility intake and processing as being key to both quality and efficiency improvements. Use of the new IT system has reduced errors and improved statewide consistency by removing decision-making from individuals and assuring that incomplete applications cannot be processed. The system has improved staff productivity, allowing a low staffer-to-caseload ratio. While focused on increasing enrollment in health coverage, it has also allowed health care providers to become "one-stop" shops for child care and Food Stamp benefits, in addition to MassHealth. Medicaid officials noted that implementation of the Virtual Gateway reduced "ownership" of cases by individual state eligibility staff, a fairly significant cultural shift that had to be addressed.

Performance is measured by the enrollment penetration rate, not just in Medicaid but in all state-supported health coverage programs, and Massachusetts reports a high level of enrollment as a result of the Virtual Gateway's accessibility and one-stop approach.

The state develops training curricula for front-line eligibility staff, both state workers and hospital and health center staff, and trainings are held quarterly, or as needed. While attendance is voluntary, participation is always strong, particularly among community provider staff.

Ohio. Ohio Medicaid officials reported that the deficiencies in the eligibility computer system have required the state's Department of Job and Family Services staff to be "extra vigilant" about identifying and responding to errors by county eligibility staff. State Medicaid staff review county performance as it relates to standards for promptness and cases denied, principally to identify areas for improved communication and focused training. Reviews can include state staff monitoring of certain eligibility decisions on a weekly basis to find and correct common errors made as a result of missing systems edits. On-site case reviews and a computerized statistical database are also used to ensure that county offices understand how to apply Medicaid eligibility rules. The state monitors county performance through Medicaid Eligibility Quality Control reviews as well. The state remains concerned, however, about inconsistency and errors in the current eligibility process, although officials report some advances through collaboratively designed staff "work-arounds" and targeted (if difficult to achieve) success with computer system patches.

State-county collaborations focus especially on identifying, prioritizing, and responding to problems within the Medicaid eligibility process. The Department of Job and Family Services has made a concerted effort in recent years to include county staff early in discussions of any policy or procedural change expected to affect county workers or beneficiaries, and to engage county staff in user acceptance testing for computer system changes. The Department's Medicaid staffers are responsible for communicating policy and process changes and for training county staff and providing technical assistance, both on-site and through video conferencing, and through a newsletter.

Ohio has no performance incentives or sanctions related to Medicaid eligibility processing by county departments. This puts Medicaid performance improvement efforts at a disadvantage, state staffers believe, given the incentives or sanctions for county departments that do exist for the state's TANF and Food Stamp eligibility systems.

Conclusion: Lessons for New York

Every state must administer eligibility for its Medicaid program. State approaches to the task of determining Medicaid eligibility are unique, with differing structures, and with variations in the degree functions are administered directly by the Medicaid agency or delegated to other state agencies, the role played by local government agencies, whether eligibility staff are located in local, regional, or central offices, whether eligibility is determined centrally or locally, and the extent of automation of the process. Application processes, underlying eligibility policies, and oversight activities also vary across the states.

Interviews with Medicaid eligibility officials in the six case study states elicited a wide range of experiences and important “lessons learned,” including some exemplary practices that New York may wish to consider as options to help achieve improved outcomes. Key findings addressed six major issue areas.

Creation of a “Health Care Front Door”

While New York and many other states continue to use a shared eligibility system for Medicaid and other social service programs, a number of states have moved over the last decade to create a new eligibility process dedicated to Medicaid (and other health programs) alone, and completely separate from cash assistance and other supports. The goal of a health care front door approach is to improve take-up rates and reduce the number of uninsured by making it easier to apply for and be enrolled in health coverage, and by eliminating any stigma of “welfare” that might discourage persons from applying for coverage. This last point has become increasingly relevant, since the vast majority of persons covered by Medicaid today do not receive cash assistance, and Medicaid eligibility is no longer federally linked to welfare eligibility.

In states with a health care front door, the Medicaid agency is entrusted with sole responsibility for organizing and administering the Medicaid eligibility process, rather than using a system shared with or managed by the state’s public assistance, human services, or social service agency. Several front-door states offer applications for health coverage only, although some also make a unified application (for health care plus other social services) available. In those states, the information technology system allows eligibility to be determined simultaneously for multiple health and social service programs, or applications to be forwarded to other programs for processing. States using a health care front door approach believed it helps improve participation rates in Medicaid and other health programs.

Community Assistance

States generally agreed that an important element of their strategy to increase health coverage was to involve community and provider organizations in outreach, consumer education, and assistance with applications. Because these community organizations are local resources, in the neighborhoods and close to the people they serve, they are trusted by applicants and enrollees. They are able to answer questions, suggest resources to address individual problems, and assist with applications. State officials regarded them as an invaluable resource.

Some states indicated that community assistance is most effective when it is coupled with access to the eligibility system through information technology tools such as electronic submission of applications or telephone application and renewal capabilities. Information technology can help states ensure that community and provider organizations have the best information possible and that their assistance is accurate.

State versus Local Administration

Among the states selected for this analysis, those with state-operated eligibility structures were more likely to have adopted and successfully implemented significant operational reforms to improve performance of the eligibility process, compared to those with locally operated administration. This may indicate that state-administered programs are better positioned to undertake statewide improvements in workflow design and support those reforms with upgraded technology.

Before statewide change can occur in county-operated programs, it is necessary to engage and secure the buy-in of local governments and their staffs. More time and effort may be required to establish and reach agreement on shared goals, implement policies and initiatives, achieve a consistent application of eligibility policy, and accomplish specific goals such as error reduction and improvements in enrollment rates. Officials in states with state-operated eligibility processes were more likely to believe that they were in a position to implement policies that would improve program performance and eligibility-related outcomes.

Performance Measurement

State officials believed that there is value in establishing, monitoring, and measuring specific goals for performance. States that had identified specific goals and established measures of performance could demonstrate that they had achieved improvement toward those goals.

One state, for example, indicated that it had established a quality improvement process focused on improving retention. The process engaged front-line eligibility workers and encouraged “creative risk-taking” by staff. This state believed its success in improving retention was a direct result of this process. Another state that established performance measures reported that it had seen improvement in the targeted measures even in a period of caseload growth and understaffing. That state also used financial incentives, and believed that the combination of incentives and linking performance to specific measures helped move the program in the desired direction.

Most states in this review did not use the official Medicaid Eligibility Quality Control process, but had obtained a waiver to measure performance in a manner designed by the state. At the time of our survey, no state had official data from federal PERM reviews; these reviews will not address issues relating to take-up rates and program penetration, but may eventually provide uniform data across state Medicaid and SCHIP programs on the accuracy of claims payment and beneficiary eligibility.

States emphasizing performance measurement appeared to have identified issues of particular importance to each state, rather than to have adopted a common set of measures used across states. States most often mentioned measuring accuracy, timeliness, total enrollment rates, and various reenrollment or retention measures, however.

Use of Information Technology

States reported that information technology can be a powerful tool for improving Medicaid eligibility processes and achieving goals such as improved efficiency, accuracy, timeliness, and consistency. Without question, the effective use of IT can reduce errors when determining eligibility for applicants and when implementing new statewide eligibility policy. Eligibility determination algorithms, which can be implemented through electronic and Web-based applications, can ensure consistency by removing individual worker judgment from the process.

State officials reported that information technology was most useful in improving performance when it was paired with improvements in workflow for eligibility workers and simplified processes for applicants. When IT is used to communicate with and among eligibility workers, state officials believed it is also associated with improvements in retention and take-up rates.

Most of the case study states reported a preference that oversight of the eligibility computer system be consolidated under the management of the Medicaid program. California described advantages to a county-operated eligibility process, but the state acknowledged significant challenges with timely and consistent implementation of policy changes, since any change must be implemented through four county-contracted eligibility computer systems. Florida, however, reported great satisfaction with the highly automated eligibility system operated by its sister state agency, noting that there is routine performance monitoring and strong collaboration between the agencies on systems operation.

Managing Program Change

State officials in this review cautioned that it was important to be aware of the challenge of managing a significant process reform that affects front-line eligibility workers. Staff who have taken pride in their work for years under a long-used Medicaid eligibility structure cannot be expected to embrace significant change unless they understand how changes will improve the performance of the program. One state indicated that adoption of a more automated system was a significant cultural shift for front-line workers. Another state cited challenges related to changing the perception of Medicaid, from “welfare” to simply “health insurance.” Another described issues that arose as it created more centralized Medicaid and SCHIP eligibility processes.

State officials emphasized the importance of addressing issues of change that affect eligibility staff. States that successfully achieved significant improvements in eligibility administration indicated that they had engaged front-line staff in the development of new processes, and that training and communication were important at every stage of the process.

In summary, the collective experience of the six states reviewed for this analysis suggests that there are several organizational and operational options that New York could consider as it develops strategies to improve take-up and renewal rates for Medicaid. The review confirmed that no two states are organized or carry out these functions in exactly the same way. Each state has adopted approaches, however, that might well be adapted by New York in a way that would improve take-up rates for existing health programs such as Medicaid and SCHIP, and that would increase health insurance coverage among the low-income, uninsured populations these programs are designed to serve.

Appendix

Medicaid Eligibility Operations and Accountability Study Interview Guide

Health Management Associates has been asked by the New York Medicaid program to talk with officials in a few targeted states about their administrative structures related to Medicaid eligibility determination. The goal of the project is to identify organizational insights and administrative best practices to assist the New York Medicaid program as it seeks to improve the effectiveness of its eligibility system. The following questions are focused on administrative structure, process, and management controls – not on specific eligibility policies.

A. Organization of Eligibility Administration

1. Please identify what Medicaid eligibility-related responsibilities are held by the entities listed below:
 - Single State Agency for Medicaid
 - Other state agencies
 - Local public agencies
 - Other local entities (providers, health plans, community organizations)
 - Vendors/contractors
2. Are eligibility staff located in a centralized location, decentralized locations, or both?
3. If local or other regionalized eligibility staff are used in the state, what types of policy, process, or administrative decisions are allowed to be made at the local or regional level?
4. Roughly what percentage of annual Medicaid applications is submitted through each group of entities?
 - Single State Agency _____%
 - Other state agencies _____%
 - Local public agencies _____%
 - Other local entities _____%
 - Vendors/contractors _____%
5. Which agencies or entities are able to access the Medicaid eligibility computer system to use the data within? To make changes to the data within?
6. Is your state's Medicaid eligibility computer system used solely for Medicaid or is eligibility for other programs, e.g., TANF and Food Stamps, also maintained on the same system?
7. Do local governments provide funding for Medicaid administration or services?

B. Application Process

8. Do your state's application methods and/or forms vary by category of eligibility, e.g., are methods/forms for children and/or pregnant women different than for the elderly and disabled?
9. Does your state use a "common application," i.e., an application for non-health care coverage programs, such as TANF or Food Stamps, in addition to Medicaid?

10. Does your state use an electronic application?
11. Does your state use a passive renewal process for any eligibility group?
12. Roughly what percentage of annual Medicaid *applications* begins with each of the following application methods?
 - In-person visits _____ %
 - Phone applications _____ %
 - Mail-in applications _____ %
 - Web-based/electronic applications _____ %
 - Other methods (specify types) _____ %
13. How has your state implemented the “out-stationing” requirement?
14. How has your state implemented IEVS requirements for income verification?
15. Does the process for re-determination of eligibility differ from what was described above?
16. Does the process for determining SCHIP eligibility differ from the process described above?

C. Accountability Processes

17. Please describe how performance is measured and monitored for each entity involved in the eligibility process. Include internal controls that assure compliance with federal and state policies; any performance measures related to quality, consumer satisfaction, take-up rate, etc.; any fiscal incentives; reporting requirements; etc.
 - Single State Agency
 - Other state agencies
 - Local public agencies
 - Other local entities
 - Vendors/contractors
18. How does your state handle MEQC activities?
19. Are your state’s Medicaid eligibility computer system and MMIS computer system maintained by staff in the same organization? Is the current arrangement satisfactory?
20. What communication and/or training methods have you found to be most effective for coordinating eligibility processes and sharing eligibility policy and required procedures across agencies and entities?
21. Please describe a recent eligibility reform (process or policy or administrative) that was intended to improve the effectiveness of the system.
22. How did you assure effective implementation of the reform throughout your eligibility system?

D. Effectiveness of Process/Organization

23. What advantages do you see to the structure of your state's Medicaid eligibility administration?
24. What challenges does your state's Medicaid eligibility administrative structure present?
What challenges related to the administrative structure affect some groups more than others?
25. How did your current administrative organization enhance or hamper effective implementation of the reforms described in question 21?
26. What challenges has your state identified in terms of process and organization of eligibility determination, and what reforms would you recommend to address these challenges?
27. What Medicaid eligibility administration strategies have had a positive or negative impact on the Medicaid program in your state?
28. On a scale of 1 to 5 (1 = poor, 5 = excellent), how would you rate your state's Medicaid eligibility administrative structure on each of the following variables?
 - Application process ease for applicants
 - Re-determination ease for beneficiaries
 - Accuracy of application process
 - Accuracy of re-determination process
 - Statewide consistency of the application process
 - Statewide consistency of the re-determination process
 - Impact on Medicaid take-up rate
 - Impact on beneficiary turnover
 - Cost-effectiveness of application process
 - Cost-effectiveness of re-determination process
29. Do you have estimates of the take-up rate for various Medicaid populations?
30. On a scale of 1 to 5 (1 = poor, 5 = excellent), how would you rate the quality (i.e., accuracy and effectiveness) of the tasks performed by the following types of entities that you've indicated above participate in Medicaid eligibility administration in your state?
 - Single State Agency
 - Other state agencies
 - Local public agencies
 - Other local entities
 - Vendors/contractors

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