

Maximizing Enrollment

Transforming State Health Coverage

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Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and Exchanges

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Executive Summary

In 2014, millions of Americans will be eligible for more affordable health coverage through Medicaid and new insurance marketplaces called exchanges as a result of the Affordable Care Act (ACA). Maximizing enrollment and providing high-quality customer service in a seamless system of public and subsidized private coverage will require collaboration, coordination and communication between all of the agencies and entities that administer the range of insurance affordability programs. Now is a critical time for states to think broadly about their coverage and consumer assistance goals and use those goals to drive their policy, staffing and technology decisions.

The ACA's vision for real-time eligibility through a web-based process holds the potential to revolutionize enrollment in public coverage, while setting a baseline for accessing coverage through exchanges. Harnessing technology will have substantive implications on current paper-driven business processes and staff roles in Medicaid and the Children's Health Insurance Program (CHIP). Given the large number of people accessing coverage, facilitating self-service pathways for consumers will enhance their experience and reserve limited state resources for those who need a human touch. New tools such as e-communications and online accounts or chat offer cost-effective ways to assist consumers using web-based services. However, technology will not replace the need for personalized consumer assistance, and the ACA assures that multiple paths to enrollment and renewal – online, over the phone, via the mail and in person – are available through its “no wrong door” requirement.

In preparing for the transformative changes ahead, leadership matters and an effective communications plan and stakeholder engagement strategy is critical to achieving new expectations for high-quality customer service. It will be smart for states to involve current staff in developing new business processes and reassessing staff roles as a first step in identifying new skills, training needs and performance expectations going forward. Collecting, analyzing and acting on data will also be critical in achieving coverage and customer assistance goals, as well as in identifying and acting on opportunities to improve performance over time.

A number of key factors drive the need for integrated or well-coordinated consumer assistance including the ACA's no wrong door approach, efficiency and economies of scale. The most compelling reason, however, are the needs of consumers, particularly those with fluctuating incomes who will transition back and forth between Medicaid and the exchange and families who will be covered through multiple programs (i.e., parents in the exchange and children in Medicaid or CHIP). States may find that pooling their resources to integrate customer services will not only be cost-effective but also result in higher-quality customer service, greater consumer satisfaction and more continuous coverage for individuals enrolled in these programs.

Introduction

In 2014, millions of Americans will be eligible for more affordable health coverage through Medicaid and new insurance marketplaces called exchanges as a result of the Affordable Care Act (ACA). The ACA envisions a streamlined system where high-performing information technology (IT) systems will reduce paperwork and determine eligibility for most consumers online, in real-time. This vision has significant implications for staff roles and business processes in Medicaid, the Children's Health Insurance Program (CHIP), and exchanges. Now is a critical time for states to think expansively about their coverage and consumer assistance goals and use those goals to drive their policy, staffing and technology decisions.

Access to user-friendly eligibility and enrollment will not supplant the need for consumer assistance, or customer service, as it is known in the insurance industry. The “who, what, when, where and how” of consumer assistance will evolve as states harness technology to manage the complex requirements of real-time eligibility and electronic verification, and as more people gain coverage through a new world of premium tax credits, qualified health plans (QHPs) and open enrollment periods. New technology-enabled consumer assistance tools, such as online chat and electronic communications (e-communications), and technology-related staff roles, including IT program managers and business analysts, will emerge as states automate eligibility and provide seamless access to expanded public coverage and the new private health insurance options.

This paper focuses on the various ways states can help customers connect to coverage and explores how current consumer assistance will change as new tools are deployed and technology transforms the enrollment process. The paper draws on the experience of states that have advanced children's coverage and pioneered the IT system improvements that inspired the ACA's vision for technology-enabled, consumer-friendly enrollment. Where state use of new technology tools is limited, such as online chat, we offer best practices in customer service management from other industries. In the paper, the terms customer service and consumer assistance are used interchangeably, reflecting the vision of a system that merges public coverage and the new exchange QHPs into a seamless continuum of coverage options enabling consumers to successfully apply, enroll, transition, and retain coverage.

Maximizing enrollment in this seamless system and providing high-quality customer service will require collaboration, coordination and communication among all of the agencies and entities that administer the range of insurance affordability programs – Medicaid, CHIP, the Basic Health Program (if applicable) and state or federal exchanges. Two key factors, beyond efficiency and economies of scale, drive the need for integrated or well-coordinated consumer assistance. First, families and individuals with fluctuating incomes will transition back and forth between Medicaid and the exchange¹ and many families will be covered through multiple programs (e.g., parents in the exchange and children in Medicaid or CHIP).² Second, the ACA's “no wrong door” approach requires that states provide access to all coverage options regardless of how and where consumers apply. States may find that pooling their resources to integrate customer services will not only be cost-effective but also result in higher-quality customer service, greater consumer satisfaction and higher coverage gains resulting from reduced churning of consumers on and off of coverage programs.

A state's infrastructure and approach to implementation will significantly impact how customer services are delivered. To what extent will the different state agencies integrate or coordinate consumer assistance? What lessons can be learned from states that have separate CHIP programs about seamless coordination with the Medicaid agency? How robust will state navigator and community-based application assistance programs be, and will they target those who are less likely to manage the online system on a self-service basis? What role will counties, contractors and community partners play in planning and implementing health reform? Are county and local human service agencies ready to tackle the addition of premium tax credits and QHPs? Will states take full advantage of cost-effective consumer assistance tools that technology provides such as e-communications, online

chat and sophisticated phone systems? How far will technology and data sources take states toward real-time eligibility and automatic renewals? Will states adopt a continual process improvement approach and take steps to capture and assess data with a critical eye toward improving consumer assistance over time? This brief touches on these and other strategic decisions that provide the framework for developing and implementing a customer service plan to meet the assistance needs of consumers and deliver a first-class customer experience in 2014.

Background

Building on state technological advances in Medicaid and CHIP, the ACA envisions a web-based application and enrollment process that will tap electronic data sources to deliver real-time eligibility decisions. While the ACA's vision is to move toward paperless, electronic systems that will verify eligibility immediately, the law ensures that consumers also can apply via the telephone, in person or through the mail and get the assistance they need to connect with coverage.³ To be able to implement these requirements, states will need to transform their systems to provide for electronic and telephonic signatures, electronic data matches with state and federal sources of data, and electronic interfaces to transfer information between programs.⁴

To hasten this technological transformation, the federal government is providing states with unprecedented enhanced federal funding for systems development: fully funding exchange IT systems through exchange establishment grants and financing 90 percent of the cost to upgrade or replace Medicaid eligibility systems that meet certain federal standards. This time-limited opportunity, available only through 2015, is prompting almost all states to embark upon major systems development projects.⁵

Under the ACA and existing Medicaid law, states are required to provide consumer assistance that is accessible for all individuals, including people with disabilities or limited English proficiency. Specifically, exchanges are expected to directly assist consumers, operate a toll-free call center and maintain a robust Internet website that, among other things, allows consumers to apply for eligibility for financial assistance; compare QHP benefits, costs, and quality ratings; and select and enroll in a plan. Exchanges must also establish a navigator program by making grants to community or consumer focused nonprofits and other eligible public or private entities to conduct outreach and directly assist consumers in accessing coverage.⁶ Medicaid agencies must provide accessible assistance with the application and redetermination in person, over the telephone, and online. Additional federal guidance is expected to further address the assistance needs of diverse populations.⁷

It is important to note that generally the ACA's requirements impact only the categories of Medicaid where eligibility is based on income and pregnancy. It changes the basis for determining income and household size for these Medicaid groups to be consistent with eligibility for advance premium tax credits (APTCs) and cost-sharing reductions in the exchange. Eligibility for the disabled and dual eligible populations remains unchanged. While these consumers could begin the process and be screened for other categories of Medicaid online, due to the complexity of their cases and state paperwork requirements, it is unlikely they will be able to complete the application process online and experience real-time eligibility. Medicaid agencies will need to maintain the capacity to provide assistance to ensure these consumers do not slip through the cracks.

HELPING CONSUMERS ALONG EACH PATH TO ENROLLMENT AND RENEWAL

This first section discusses state experience with the various “no wrong door” paths to enrollment and renewal and how the ACA will impact the way they are operationalized in the future. Figure 1 illustrates the different ways customer service can be delivered depending on the path to enrollment, clearly showing that not all forms of assistance are conducive to all paths to enrollment and renewal. The expected volume of applications and renewals is based on the experience of states that currently offer multiple paths to enrollment and renewal, combined with feedback from state officials who believe the shift from a culture of paper applications will take

time. The next section will discuss how new technology-based customer service tools can be integrated with proven consumer assistance methods to support enrollment and renewal. Lastly, the paper will address key strategic considerations impacting the integration of technology and consumer assistance tools.

FIGURE 1 – PATHS TO ENROLLMENT AND POTENTIAL ASSISTANCE METHODS							
<i>Paths to Enrollment</i>	<i>Estimated Volume</i>	<i>Online Account</i>	<i>Online Chat</i>	<i>E-mail or Texts</i>	<i>Phone Support</i>	<i>In-Person*</i>	<i>Regular Mail</i>
NEW APPLICATIONS							
Online Applications	Moderate to High <i>(increasing over time)</i>	✓	✓	✓	✓	✓	✓
Telephone Applications	Moderate			✓	✓		
In-Person Applications	Low	✓				✓	
Paper Application	Moderate <i>(decreasing over time)</i>				✓	✓	✓
RENEWALS							
Automated Renewals	High	✓	✓	✓	✓		✓
Online Renewals	Moderate	✓	✓	✓	✓	✓	✓
Telephone Renewals	Low				✓		
In-Person Renewals	Very Low	✓				✓	
Paper Renewals	Low <i>(decreasing over time)</i>				✓	✓	✓
* In person assistance is offered by states in different ways as explained below.							

ONLINE APPLICATIONS

A web-based application, supported by a rules-based eligibility engine and electronic linkages to eligibility information, offers a powerful tool to expedite the application and enrollment process. Through dynamic questioning and by tapping data sources to verify eligibility along the way, the system can skip questions not relevant to an applicant's circumstances. The system also can prompt for missing information to ensure that applications are complete, often found to be a bottleneck in the current processing of paper applications.

With so much focus on technology providing a streamlined path to coverage, it is reasonable to assume that a majority of consumers will apply online and receive an immediate decision. In Oklahoma, the first state to launch a real-time eligibility system, 92 percent people who are eligible to apply online do so and 100 percent receive an immediate determination.⁸ Whether other states are able to reach Oklahoma's high rates of online applications and real-time decisions will depend on how easy the system is to use, whether useful electronic data sources are available, how quickly data-sharing agreements can be executed and the quality of electronic data sharing interfaces.

Despite Oklahoma's success, how quickly consumers will embrace the web-based path to enrollment remains unclear. State Medicaid and CHIP administrators' caution that the cultural transition from paper to web-based applications will take time for both staff and consumers, and much of the experience with electronic applications supports their conclusion.⁹ While 32 states currently have Medicaid and CHIP online applications,¹⁰ the percentage of applications received online varies notably depending on the state.¹¹ For example, Alabama reports that only 20 percent of applications come through the web, even though the state implemented electronic signatures in 2004 and has prominently promoted its website through outreach and program materials.

Given the efficiency of online applications and the potential of real-time eligibility, states may want to consider a variety of proven strategies to increase usage of web-based applications (see Box 1). As a first step, states may want to look closely at state experience with online applications. A Wisconsin study identified the lowest-income, rural, and non-English speaking populations as least likely to choose an online method,¹² which is consistent with research on low Internet usage in general.¹³ Notably, smartphones and other mobile devices extend the reach of the Internet to more people – particularly African Americans and English-speaking Latinos.¹⁴ Thus states can make the online application for accessible to a greater number of eligible individuals by ensuring that it is enabled for mobile devices.

States also may want to consider adopting other technologies – such as real-time translation and interpretation services through phone lines, and audio-visual application tools that translate into other languages to make online applications more accessible. Alabama offers a specialized electronic application that provides Audio Visual Application Assistance (AVAA). AVAA features computer-facilitated interactive audio and video capacity in both English and Spanish and is intended to lower barriers to applying online due to language and literacy.¹⁵

TELEPHONIC APPLICATIONS

Only a handful of states currently offer new applicants the opportunity to apply over the phone. States report they lack the staff resources required to process phone applications and the systems to efficiently meet the signature requirement.¹⁶ In Virginia, one of the few states taking applications over the phone, telephonic applications represent about 20 percent of all new applications.¹⁷ Both Virginia and Wisconsin record a “telephonic” signature, or voice recording affirming the same attestations required by signature. If states do not implement a recorded telephonic signature, they could send a form in the mail to be signed and returned by the applicant or suggest the applicant sign the application via an online account. These alternatives could delay enrollment and potentially increase staff time spent tracking down and processing signed forms.

Additional federal guidance permitting state flexibility in designing telephonic application processes is expected. States may want to think through and test different strategies, but a specific worker web portal designed as an interview and data-entry tool could expedite the process. Regardless of a state's process, it will be helpful to ask applicants to have needed information (e.g., Social Security Numbers) available before starting the application.

IN-PERSON APPLICATIONS

All states have local offices of health and human services, run by the state or counties, where people can apply for health coverage and other public assistance programs. Currently, people applying in person are often required to complete a paper application and then sit with eligibility staff who review the form for completion and clarify needed documentation. Workers also complete the forms on behalf of consumers with literacy, language, cultural, cognitive or physical barriers. One-on-one assistance, while clearly needed, is the most human-resource intensive of all assistance types. As with phone applications, it may be useful for eligibility workers to have access to a web portal specifically designed as an interactive tool to collect and enter data directly into the eligibility and enrollment system.

Not everyone applying in person needs intensive individual assistance; some may simply need access to computers. "Kiosks" or computer workstations placed in offices for consumers to use allow workers to spend more time with those who need fully facilitated, in-person assistance.¹⁸ However, current use of enrollment stations or kiosks has met with mixed results. Alabama's CHIP agency found that the number of people using kiosks increases when staff or assisters encourage them and are available to answer questions.¹⁹

Customer-Friendly Assistance Encourages Use of Enrollment Kiosks

Co-locating customer-oriented staff to support consumers may increase the use of kiosks or enrollment stations located in public offices or libraries. States also may want to think about locating them in places that provide health care services, where consumers are most likely to be thinking about health coverage and are more motivated to apply.

Medicaid agencies also provide in-person assistance by out-stationing eligibility workers in places other than government offices, often in hospitals and community health centers. Many states partner with community-based organizations to connect the hardest-to-reach consumers with coverage. These existing assistance programs provide a foundation on which states can build navigator programs, required by the ACA, to serve vulnerable and underserved populations.²⁰ (More discussion on navigators and assisters appears later in this paper.)

PAPER APPLICATIONS

Paper applications continue to be widely used in Medicaid and CHIP. State experience with online applications illustrates that individuals have differing comfort with, trust of, and access to the web, and therefore may continue to use paper applications for some time. For example, Virginia's central eligibility processing unit has been accepting online, phone and paper applications since the start of 2011 (in-person applications are accepted at local offices). Data from the most recent six months show that more than 20 percent of new applications continue to be submitted on paper via mail or fax.²¹

The new single, streamlined model paper application for all insurance affordability programs has yet to be released, so it is too early to assess how easy it will be to complete on a self-service basis and if paper will persist as a popular path to enrollment. Regardless, a paper application will take longer to process than the online application and denies consumers the benefits of real-time eligibility.

Offering paper applications is an ACA requirement; however, the current paper-driven process in Medicaid and CHIP is riddled with issues such as incomplete or unsigned forms and/or misplaced paperwork, causing processing delays and leading to procedural denials. While state experience with online applications varies

widely, a recent study of lower-income adults in Alabama, Maryland and Michigan suggests that almost three-quarters of people are interested in enrolling online. Taking steps to maximize use of online applications will increase administrative efficiency and provide consumers with a smoother, faster path to coverage

BOX 1 – 10 STRATEGIES FOR INCREASING ONLINE APPLICATION VOLUME

- 1) Make sure the online system is consumer tested and easy to use.
- 2) Feature the web link to the online application and prominently promote the availability of help in all outreach and marketing materials.
- 3) Monitor the times of day that consumers use web-based applications and match the availability of live consumer assistance to peak periods of use.
- 4) Provide and highlight multiple ways for online consumers to access help:
 - Offer chat through a “click to chat” icon or a pop-up box that appears when an applicant lingers for an extended period indicating they may need help.
 - Promote a toll-free number; or “click to call” button (a process by which the click triggers a customer support representative to call the applicant).
 - Allow applicants to submit e-mail questions in a secure environment.
 - Enable co-browsing, so that customer service representatives can see the actual screen where a consumer needs assistance.
- 5) Monitor where consumers abandon the application and track frequently asked questions in order to improve the ease of use.
- 6) Develop smartphone and mobile device versions of the application to reach demographic groups more likely to use these devices than computers.
- 7) Direct navigators to target demographic groups and geographic areas where use of the online application may be low and create a navigator portal they are required to use to facilitate electronic applications.
- 8) Set up computer stations or kiosks in public assistance and health provider offices and have staff available to encourage their use and assist applicants with questions.
- 9) Create a worker portal for the online application as an interactive tool for facilitating telephonic and in-person applications with linkages to key eligibility data.
- 10) Alert consumers waiting in a phone queue or at a local office of the wait times and encourage them to use online services, highlighting the availability of assistance.

ANNUAL RENEWALS

The automated and administrative renewal processes required by the ACA accelerate the evolution that states have embarked upon in recent years in simplifying renewals to gain administrative efficiencies and improve retention.²² Twenty (20) states have implemented some version of administrative renewals, a process by which the enrollee can be re-enrolled using a streamlined procedure, or is sent a form prepopulated with information available to the Medicaid or CHIP agency.²³

- Louisiana, which has made the greatest strides toward streamlining renewals, renews 75 percent of Medicaid cases through a variety of administrative renewal processes, including ex parte reviews and express lane eligibility. Notably, less than 1 percent of enrollees lose eligibility at renewal for non-eligibility related reasons.²⁴

- Virginia’s CHIP program sends out pre-populated renewal forms, however, all enrollees must attest to the information even if there are no changes. The state provides multiple paths for this attestation or reporting changes, including online, over the phone or returning the form by mail. The most recent data indicates that the paper form remains popular, with nearly two-thirds of renewals returned by mail (49%) or fax (16%), while 30 percent are submitted online and 5 percent telephonically.²⁵

In addition to administrative renewals, the popularity of online or phone renewals has increased over time, leading to further decreases in the volume of paper renewals.²⁶ However, the current manner in which states offer multiple paths to renewal work may not directly correlate to the requirements of the ACA, which redefine how the no wrong door access points – online, by phone, on paper or in person – apply at renewal.

Moving forward, consumers will not have to provide information already available to the agency, they will only be required to report changes if the data used to automatically renew eligibility or prepopulate the form is not current. Under the ACA’s automated renewal process, the eligibility system will examine the most current electronic data available to determine if the individual or family remains eligible.²⁷ If available information confirms continuing eligibility, consumers enrolled in Medicaid and CHIP will be notified that coverage has been renewed and will only be required to report changes. The exchange will conduct a similar review of electronic data and notify enrollees of their eligibility for the upcoming year, including the level of premium tax credits and cost-sharing reductions. In turn, enrollees must report changes and will have an opportunity to switch health plans.²⁸

If states are unable to verify ongoing eligibility through automatic renewals, they must send a renewal form prepopulated with the most current data available to the agency from electronic interfaces with eligibility related databases. Most states presently pre-populate renewal forms with information in the eligibility file, rather than tap electronic databases for the most current information.

Given the highly automated nature of renewals under the ACA, the level of consumer assistance that states will need to provide at renewal should be significantly lessened. However, states will need to develop processes to act on changes reported by consumers through each access point and be prepared to interact with consumers to clarify the new information or explain changes in eligibility.

REPORTING CHANGES

While the ACA requires that renewals occur no more frequently than every 12 months, low-income families experience significant changes in income throughout the year, with the most significant fluctuation impacting families with income closer to the eligibility cutoff between Medicaid and the exchange.²⁹ Consumers will continue to be required to report these and other changes that may impact their eligibility, unless a state has opted to provide 12-months continuous eligibility for children and receives federal approval to provide 12-months continuous eligibility for adults.³⁰ Likewise, a change impacting eligibility may be obtained periodically from the state’s electronic interfaces with wage and other income sources between regular renewals.

Regardless of when changes are acted on or how they are reported, a shift in eligibility between programs may prompt the need for consumer assistance. The timing of changes and the timeliness of providing customer service will be key to avoiding gaps in coverage as consumers move between programs. States that have separate Medicaid and CHIP programs have been working for years to minimize coverage gaps as children’s program eligibility changes by ensuring that handoffs are successful. For example, New Hampshire’s CHIP program accounts for and reports the disposition of every referral to CHIP to the state Medicaid agency.³¹

Changes in eligibility are likely to create confusion, particularly in the early months and years following January 2014. Customer service staff in all agencies will need to be knowledgeable about how all programs work in order to help consumers understand what has happened and why. Aligning coverage effective dates, setting critical target dates for the timing of renewals and expediting the processing of changes can help avoid gaps in coverage. For example, if (beyond open enrollment) the cutoff for exchange QHP enrollment is the 16th of each month for the upcoming month,³² the Medicaid or CHIP agency may want to coordinate the timing of renewals and send reminders to families to report changes promptly before the deadline.

INTEGRATING NEW TOOLS WITH PROVEN METHODS OF ASSISTANCE

Given the goal to move to an electronic eligibility and enrollment process, it is fitting (as Figure 1 illustrates) that there are more ways to assist consumers who apply online, which are discussed in detail below. Although there is limited state Medicaid experience with some of the tools discussed, other businesses, including insurance and health care, recognize how technology-based consumer assistance tools and promotion of customer self-service can lower customer service costs and improve customer satisfaction. Whether these new tools are immediately deployed or phased in over time, states designing new IT systems will want to ensure they can have the flexibility to integrate these tools at a later time (preferably before enhanced federal funding for systems development expires in 2015).

With only a few states currently offering all modes of application (online, telephone, in-person, paper) in Medicaid and CHIP, the lack of robust data makes it difficult to predict which path to enrollment consumers will choose, or what mode of assistance they will use most frequently. A Washington state study on the potential role of navigators indicated that residents are split on whether they want help with the exchange online (38%), by telephone (31%) or in person (30%).³³ A different study involving Medicaid or exchange eligible individuals in three states suggest that assistance by phone or in-person will be more popular (43% to 47%) than online (19% to 28%). This same study indicates that people are who less likely to apply online would be interested in going to a government office to enroll.³⁴

As consumer assistance evolves, states may want to consider how best to communicate about and consolidate customer assistance services to combine workers/entities that offer online chat, e-communications, and phone support. In other industries, these services are physically or conceptually grouped together into one center called a customer service or contact center. Alabama has embraced this approach and is establishing and transforming local offices into customer service centers, highlighting an inclusive approach to customer service.

CUSTOMER SELF-SERVICE

Supporting a consumer's ability to access and retain health coverage on a self-service basis is as important as providing a human touch when needed. The first step in facilitating self-service is to ensure that the online application is as user-friendly as possible. To this end, the Enroll UX 2014 (UX2014) project, a public-private partnership between foundations, the federal government and 11 participating states has designed a first-class online application user interface that is available at no cost to all states.³⁵ Adopting the UX 2014 model, or using similar concepts in design, will ensure that more consumers will be able to use the online application with

Consumer Engagement in Design and Testing Technology Can Ensure that Systems Are Consumer-Friendly

It is important that states involve consumers in the design and testing of new self-service technology features before they are launched. Additionally, testing the online application's performance using different Internet browsers and computer operating systems will avoid technical problems consumers might encounter if components are not compatible. These key preventive steps can reduce or avoid problems that require consumer assistance down the road.

ease. In turn, the relative ease of use of the online application and exchange website will significantly influence the level of assistance needed by consumers. A less straightforward user design that has not been consumer tested is likely to generate lower use, and more questions and requests for assistance from consumers that use them.

One strategic way technology can promote customer self-service is to incorporate **pop-up help boxes** throughout the application. By clicking on an icon or question mark, additional explanatory information can answer common questions to help consumers continue on a self-service basis. Tracking where applicants get hung up online as well as questions received by the call center will help identify areas where help boxes may be useful or where the application can be improved.

Searchable knowledge databases, more commonly used as a tool for customer service staff, can be adapted for use by consumers. There is a range of electronic tools from well-constructed, **searchable frequently asked questions (FAQs)** to sophisticated knowledge databases that can be used to capture policy, instructions on using the online portal and technical problem fixes.

Personal online accounts are another strategy to promote self-service and reduce staff time responding to status requests and processing routine transactions such as address changes. Slightly more than half of the 32 states with electronic applications offer an online account feature.³⁶ The more robust the functionality of the customer account – from applying and renewing coverage to uploading documents (if needed) to paying premiums online to receiving e-notices – the greater the time savings for customer service staff. Utah has enabled broad functionality in its online account including allowing consumers to see the status of their application and get details about needed verifications. (For more information on Utah’s online account functions, see Box 2.)

Summary of Tools Supporting Customer Self-Service		
Tools	User	Purpose
User Interface	Consumer Navigator Worker	The user interface is the public-facing view of the online application that, if designed from the perspective of consumers, can enhance the consumer’s ease of use.
Pop-up Help Boxes	Consumer Navigator	Consumers can click on an icon or question mark in the application to read more information about the topic.
Searchable Knowledge Databases or FAQs	Consumer Navigator Worker	A searchable online database can capture policy information, commonly asked questions, instructions on for the online portal and technical issues
Personal Online Accounts	Consumer	Online accounts provide consumers with features to apply/renew coverage, check application status, receive notices, check verifications needed, update account information (e.g., address), report any changes, (e.g., income), and pay premiums (among other features).

ELECTRONIC CONSUMER ASSISTANCE TOOLS

Online chat has become a popular form of consumer assistance for web-based service providers, although there is extremely limited experience using it in Medicaid or CHIP. Chat has the benefit of being instantaneous and two-way. To support chat (as well as call centers), states also may want to consider enabling **co-browsing** – the ability of customer service staff to view the same screen as the applicant. It is a particularly useful tool for assessing whether the consumer simply needs help in using the application or if there is a technical issue.

Chat offers an alternative for consumers to ask questions that might otherwise result in a telephone call and may be more appealing to younger people.³⁷ If the experience of other industries holds true for the insurance

affordability programs, chat could become the more cost-effective way to assist consumers. One source indicates that the average response from a telephone call center costs \$33 while online chat costs \$10 per encounter.³⁸ Cost savings result from a reduction in toll-free phone charges and the fact that chat staff can handle multiple consumer requests simultaneously – five tends to be the maximum that most customer service representatives can handle well while three appears to be a best practice.³⁹ Depending on chat demand, staff can multi-task with duties that are easily suspended, such as answering e-mail, however, experience suggests it is not a good idea to have customer service staff handling phones and chat at the same time, since taking a call would interrupt prompt chat replies.

Consumers Expect Chat to Be Fast and Accurate

Chat requires strong typing skills and the ability to communicate potentially complex messages using as few words as possible. Chat support staff must be adept at picking up nuances of consumers' attitudes and needs without the aid of audio cues such as tone or volume. To avoid delays that can frustrate consumers, chat staff must be completely familiar with the products and issues they support.

Effective implementation of chat goes beyond acquiring the system components. Consumers expect chat to be fast and accurate. Thus, it is strategic to assign chat responsibility to staff familiar with Medicaid and CHIP policies and procedures, as well as all aspects of exchange operations.⁴⁰ Online chat logs provide an ideal tool for monitoring and improving chat quality over time, and have the added benefit of providing customers with a record of the information exchanged, if filed in their online account or accessed via secure e-mail. Training and monitoring of chat communications are essential to ensure clarity, accuracy and professionalism from both a quality and legal perspective. With a written record of a communication between staff and consumers, there is documented evidence that may be used in an appeal or fair hearing.

A number of states are thinking about incorporating online chat in their Medicaid systems and several, including California, Rhode Island and Maryland, have specifically included a chat function in their exchange IT system specifications.⁴¹ Arizona is building its IT system with chat capabilities and plans to track peak periods of online use to determine whether to provide chat support after normal business hours. States can draw from Utah's experience, which is pioneering the use of chat (and e-notices) in its integrated public assistance programs. Utah offers chat services during normal business hours for applicants and enrollees when logged onto the state's secure customer portal called myCase, which houses the online application and personal account features. Chat responses are prioritized to new applicants to avoid the consumer abandoning the process altogether or turning to the paper application. This is similar to a best practice in online services where an abandoned "shopping cart" represents a lost opportunity to assist a customer through the full experience from browsing to buying.⁴²

Initially, Utah used chat to respond to eligibility and programmatic questions, as well as to assist customers with "help-desk" type technical questions regarding myCase. Given limited staff resources, and the fact that newly hired chat staff had minimal policy and programmatic experience, the scope of chat was subsequently scaled back to providing assistance to customers in using the online application or account features. More involved questions received via chat are now referred to seasoned eligibility workers who follow-up with customers by phone. As Utah more fully develops its contact management systems in the future and enhances chat functionality, they plan to implement a feature that automatically routes chat requests to the eligibility teams responsible for case management, using case numbers or the customer's personal identification number. At that time, the use of chat may be expanded beyond help-desk functions. (For more information on Utah's use of technology, see Box 2).

E-Communications offer timely and low-cost delivery of notices and other client communications. Utah estimates that it saves \$12 per year for every beneficiary who opts for electronic delivery of notices.⁴³ Enrollees opt in (and may opt out at any time) to receive an alert via e-mail, text message or both that a notice has been posted to their online account. An added benefit is that these notices are stored in the account for future access, up

to 180 days. Just as mail is returned as undeliverable when no forwarding address has been reported, messages are also returned when an e-mail address or cell phone are no longer in use, ideally prompting the agency to locate the client or update the consumer's information through data sources.

In planning for implementation, states will need to decide whether they will use e-communications only to inform clients that a standardized notice has been posted to their account or if e-communications will be used for one-on-one interactions to answer specific questions or solve individual problems. In Utah, the system handles the delivery of the notice to a mailbox or online account, triggering an e-mail or text, behind the scenes. Staff initiate notices in the same way they did prior to the use of e-notices and no additional staff training or monitoring is required.

Arizona permits eligibility workers to exchange personalized e-mail with clients, most often for clients or their authorized representatives accessing long-term supports and services. Experienced eligibility staff assisting consumers over the phone handle these e-mail exchanges. Arizona state officials report high customer satisfaction among those using e-mail correspondence with no evidence of e-mail related complaints or appeals. If states use e-communications, as Arizona does, they will want to consider what training and monitoring is necessary to ensure content clarity, accuracy and professionalism, as previously discussed in the online chat section.

E-communications must occur in a secure environment, given the confidential and private nature of personal information that may be exchanged. Secure websites which house the electronic application and online accounts and secure e-mail servers, which some states like Arizona and Virginia use, can provide the necessary security to protect consumer privacy and personal information. However, states will want to adopt and promote rigorous security standards to instill consumer confidence in web-based processes and tools.

The ACA stipulates that states provide **plain language notices** that are easily understood by those with low literacy skills and offer meaningful access to individuals with limited English proficiency and people with disabilities.⁴⁴ Newer systems will make it easier for states to update notices, addressing a well-known problem and lingering relic of outdated, inflexible Medicaid eligibility systems. Plain language requirements, supported by flexible IT systems, have the potential to reduce the number of calls for assistance in interpreting confusing and contradictory notices. As part of ongoing process improvement, states will find it useful to track and refine notices that continue to raise questions from consumers. As states work to improve notices, technical assistance by way of model notices and sample language will be valuable as additional federal guidance is developed.

Incremental Rollout of Technology and Tools Can Ease the Transition

While Medicaid and CHIP staff are accustomed to receiving ongoing training on updated policies, the launch of new technology and business processes at a time of unprecedented demand for services triggered by the initial open enrollment period will create a unique set of challenges. If possible, incremental rollouts of new technologies and phased implementation of new tools will ease the transition for staff.

DIRECT CONSUMER ASSISTANCE

Telephone support is the most widely used form of consumer assistance today in Medicaid and CHIP. Some states continue to provide phone support to clients through a case management approach, where a specific eligibility worker is responsible for all activity associated with their assigned caseload. This method can be challenging and costly when consumers and staff find it difficult to connect, resulting in multiple calls and bottlenecks in the eligibility process.⁴⁵ Newer practices in administration of eligibility are moving toward a more service-oriented approach to process management, where work is queued to the next available worker or team, and call centers focus on providing information, processing reported changes, handling questions and resolving

problems. Utah takes a hybrid approach with a call center that assists consumers with general questions and the application process. Once an application is submitted, it is assigned to an eligibility team and all calls are directed to the team. The teams specialize in a particular type of case (e.g., CHIP or Long Term Services and Supports) and self-determine which team members process work or answer phones each day. This approach ensures that customers are always able to talk with a team member who knowledgeable about his or her case.

One standard in call center performance is the extent to which calls are resolved in one call, known as **first contact resolution**. Oklahoma and Louisiana have taken this approach, determining that it provides higher-quality customer service and is more cost-effective to handle each call immediately without handoffs. States that staff their own call centers indicate that experienced Medicaid and CHIP staff are ideally suited to work in the call center because their in-depth Medicaid knowledge provides them with the tools and experience to resolve any customer issue. In Louisiana, staff positions within the call center pay higher wages, which provides Medicaid eligibility workers with a path for advancement and encourages those who are experienced to apply.⁴⁶ Similar to Louisiana, Oklahoma has adopted a “one and done” philosophy that is rooted in having knowledgeable call center support staff who can answer consumer questions or troubleshoot problems without handing off the call.⁴⁷

Under the ACA, exchanges are expected to operate **call centers**, but this does not necessarily correlate to a physical space that is centrally located. Phone technology allows states to operate virtual call centers, as Louisiana and Utah do in directing calls to workers located centrally or in regional offices, as well as those participating in the agency’s work-from-home program. In establishing call centers, states will be faced with a myriad of decisions regarding innovative technology that can help manage calls, as well as monitor key indicators that can be used to improve performance. Each of the key features of these systems should be considered carefully in the design.

Interactive voice response technology (IVR) allows consumers to interact with the phone system via speech or keypad and can increase efficiency by automating tasks that would otherwise require human interaction. Flexible IVR systems can be designed to automatically handle requests for straightforward information such as a mailing address or office hours and allow consumers to select options that direct their call to the right destination. An IVR system is also a good choice for recording telephonic signatures. States interested in IVR technology may want consider other key factors, including that many consumers see them as difficult to use and that states have experienced challenges using them for certain functions.⁴⁸ For example, an IVR system may not be the best solution for gathering more than simple information, as Louisiana discovered in using an IVR for families to record renewal information. Insufficient or difficult-to-understand responses prevented them from fully processing many renewals without follow-up.

Nonetheless, IVR systems are common in call centers and can add value to the customer service enterprise if the needs of the consumer guide the system’s design. One advantage is that IVR technology can be used to encourage callers to access other forms of assistance. Utah’s system informs customers of the expected wait time to talk with a live person and refers them to online chat for a quicker response. Similarly, Arizona is building their IVR system to alert callers about the wait time and offer consumers the option of a virtual hold – that is, having the system call the consumer back when it is their turn in the queue rather than holding. Given that most states provide toll-free calling, the time customers spend waiting on hold can be expensive.⁴⁹ Virginia found that monitoring and managing queue times when using the virtual hold is critical to avoiding multiple calls if the consumer misses the initial callback.

Some states contract with outside vendors to manage their call center, which shifts the responsibility of managing peak enrollment periods to the contractor. Both Virginia and New York recommend that it is important to have flexibility in contracts with vendors, so that refinements in how the center delivers services can be implemented

easily. For example, contracts that strive for the lowest average call length could impede the implementation of new tasks requiring more time such as processing a telephonic application or renewal.

Call center management has matured over time, offering many lessons learned, as well as tools to assess center and individual worker performance. Systems offer many features that states actively use to track wait times, call length, dropped calls, call volume, handoffs and other data critical for assessing quality and improving consumer service. State experience with call centers, both staffed by state workers or contracted out, offers valuable insight to other states that will be implementing call centers for the first time as a critical consumer assistance service.

NAVIGATORS AND ASSISTERS

Exchanges are required to create navigator programs using community or consumer nonprofit organizations and other qualified entities to conduct outreach and assist consumers through eligibility, plan selection and enrollment. The breadth and depth of these programs is left to state discretion as long as state standards meet minimum federal requirements. One such requirement is for navigators to maintain expertise in the needs of underserved and vulnerable populations – consumers most likely to need help.⁵⁰ By targeting navigators effectively, states can proactively reach these consumers with extensive outreach and in-person assistance.

The Oregon Health Insurance Exchange considers navigators and community-based partners to be part of their consumer assistance network, alongside customer service staff.⁵¹ This approach is based on the state’s experience with community partnerships: a key factor in the state’s success in cutting the number of uninsured children in half in less than two years.⁵² Massachusetts, having implemented comprehensive health reform and achieved overall coverage levels of 98.1 percent of the state’s residents, affirms the need for a strong community-based consumer assistance strategy. State officials note the importance of broad public education with people on the ground who are supported with training, ongoing technical assistance and policy updates.

One strategy to increase the percentage of electronic applications, while providing tools to better assist consumers, is to create a specific web portal for navigators and assisters, such as Oklahoma offers with its “agency view” portal. The portal can take advantage of the online application’s dynamic questioning and eligibility verification process and help assisters track the progress of applications to facilitate needed follow-up. It can also provide an audit trail of activity, boosting the state’s ability to capture and analyze data to evaluate the program’s effectiveness and reach. Examples of how states are maximizing the functionality of their assister portals include:

- In Utah, assisters (with appropriate protections regarding authorized access and data confidentiality) can access state databases to assist in eligibility and verifications screening.
- Texas’ web portal allows assisters to upload scanned verification documents that link directly to the consumer’s electronic file. This speeds up the process and saves time in matching documents submitted via the mail.
- Massachusetts provides application assisters (with proper authorization) the ability to view client case information and notices. The recent addition of functionality allowing assisters to see the status of verifications dramatically reduced the volume of status request calls received by the call center.

While navigators and assisters need training and policy updates similar to customer service staff, they also are customers. States may find it helpful to dedicate specific customer service representatives to serve navigators as New Hampshire does in supporting community-based application assisters. This will ensure that assisters working with the hardest-to-reach consumers can promptly receive answers to resolve customer or technology issues. By dedicating staff to support navigators, the state is also in a better position to identify common training and communications needs.

DEVELOPING A STRATEGY TO ACHIEVE HIGH-QUALITY CONSUMER ASSISTANCE

There are many decisions to be made regarding the functionality of technology and the level of integration or coordination between agencies and their partners, and states that have undergone significant transformation strongly advise others to start as early as possible. Thinking through the intersection of systems and consumer assistance will help states reassess staff and partner roles. What will the IT system do and what needs a human touch? How will staff and partner roles evolve? What skills will need to be cultivated in the upcoming years? States can begin communicating the transformation to all key stakeholders, create a supportive environment to encourage feedback, offer opportunities to involve staff and partners in re-engineering business processes and inspire culture change.

Transforming system processes and setting new expectations for customer service requires **communications** and engagement with all key constituencies, including staff, external stakeholders and community partners. Internal and external communications regarding the new policies, guidelines and business processes will need to support the vision of a streamlined and simplified eligibility system.

- Reflecting on Oklahoma’s experience in centralizing Medicaid case management when launching its real-time eligibility system, state officials emphasize the importance of establishing and maintaining communication with all key stakeholders that conveys a positive vision. Without a unified message passed consistently through affected agencies to their frontline staff, Oklahoma’s change was misunderstood by some, and had a trickle down impact on consumers.

Many stakeholders will be information disseminators, application assisters, navigators, or outreach partners who become the first point of contact for many newly eligible consumers. They can serve as an **effective loopback mechanism** to the state regarding consumer experience and how policy is working on the ground level.

- Massachusetts, which partners with community organizations and service providers who facilitate 60 percent of the applications received by the state, has institutionalized routine regional trainings, policy updates and regular meetings with advocates. The state uses these venues as an opportunity to receive feedback and brainstorm opportunities to better serve consumers.

In states with county administered eligibility, **county collaboration** is another critical aspect of ensuring high-quality consumer assistance.

- North Carolina is addressing coordination challenges in its plan to implement new technology and streamline eligibility among all public assistance programs.⁵³ Engaging county leadership, setting expectations while providing flexibility for implementation, and creating a strong communications plan are key elements of their initiative. (For more details on North Carolina’s initiative, see Box 3).

Change can be difficult for staff; however, **leadership** can reduce concerns and fears by embracing two-way communication about the changes ahead. A structured approach for planning and managing change developed early on — beginning with the leadership team and then engaging staff and key stakeholders — can be refined often as change moves through the agency.⁵⁴ States at the forefront of coverage gains cite the crucial role of leaders who are flexible and team-oriented, create a positive and safe environment to encourage employee feedback and demonstrate that they value employee input. The strategies in these states mirror those promoted as best practices in change management where strong leadership, building ownership by involving staff and reinforcing progress through recognition and incentives (when possible) are proven ways to inspire and support change.⁵⁵

- Massachusetts’ success in covering 99.8 percent of the state’s children, despite not having adopted many of the key policies known to encourage enrollment, can be attributed in part to a long-standing culture of coverage supported by leadership, rather than a gatekeeper approach to eligibility.⁵⁶
- Louisiana’s success in virtually eliminating the loss of coverage at renewal due to paperwork or procedural issues has been enabled by creating a culture of coverage and a commitment, at all levels of the organization, to the goal of keeping children covered.⁵⁷

Process improvement is also a key tool in managing change since change precipitates new business processes that often need refinement based on actual experience. States can use lessons learned by government and the private sector in adopting improvement methodologies to achieve efficient, customer-centered delivery of services.⁵⁸

- Louisiana’s unrivaled success in improving retention is a direct result of culture change and integrating process improvement in their management toolbox.⁵⁹ Today, Louisiana strives to fill supervisory or management positions with forward thinking candidates who have demonstrated proficiency in process improvement management.

Due to changing roles and expectations of staff, reassessing all aspects of human resource management—job descriptions, classification, hiring, training, staff development and performance expectations—will be essential. **Staff engagement** is a proven strategic in developing new business processes and reassessing staff roles as a first step in identifying skills, training needs and performance expectations. By empowering current staff to think through new business processes, states can identify how staff roles will evolve while achieving necessary buy-in to promote cultural change. Engaging staff in the planning process will also increase the number of problem solvers who are on hand during start-up and peak enrollment periods.

As we move toward 2014, staff will have new systems, policies and procedures to learn. Broader and more complex program knowledge will be required with new coverage options and the role and financial implications of advanced premium tax credits and cost-sharing reductions. The adoption of new consumer tools including online chat and electronic communications require the development of new **training** and skill building exercises, as well as quality monitoring activities, which may be challenging to implement during peak enrollment periods. Technology can support this effort through training webinars and online classes to supplement in-person training.

Due to state budgetary restraints, many Medicaid and CHIP agencies are uncertain about their ability to add new staff in preparation for the ACA’s coverage expansions. As a result, states will want to pay special attention to **retraining** and the professional development of existing staff. With hiring freezes in many states, Medicaid agencies are also dealing with the loss of senior staff, often to early retirement options. This is another reason states may want to consider developing searchable databases to capture the knowledge of experienced eligibility and policy staff.

**Skills to Effectively Use
Technology and Provide
High-Quality Custom Service**

As states redefine staff roles, important skills and qualifications to consider include flexibility, computer aptitude, customer service skills, reasoning, trouble-shooting proficiency, and affinity for the mission of connecting consumers to coverage. New business analyst-type roles will emerge for the purpose of monitoring how well the systems are performing and to serve as a liaison between technical and policy staff.

- When it assumed responsibility for Medicaid eligibility, the Oklahoma Health Care Authority hired new staff to join experienced policy staff in its new call center. Recent hires, selected for their customer service skills and computer aptitude, easily mastered the “systems side of things” but were new to policy.

On the other hand, existing staff was slower to adapt to the new technology but had deep knowledge of eligibility policy. Early experience prompted managers to physically alternate new staff with senior staff (cubicle by cubicle) so they could turn to one another in real time to assist clients immediately with either technology or policy related issues. This strategy could be effective if temporary workers are used during peak periods of work associated with open enrollment in the exchange.

States have an opportunity, and a need, to redefine **performance expectations** and evaluate performance in terms of customer experience and coverage goals. To perform well, employees want to know what is expected of them, which can be achieved through clear job descriptions that describe essential functions, tasks and responsibilities and align expectations with the goal of high-quality consumer assistance.

- Utah has adopted an innovative performance based bonus system to incentivize staff to exceed productivity and accuracy goals. An average number of eligibility determinations, which includes new applications, renewals and reported changes, is set for each team based on the type of cases they manage (e.g., long term supports and services, CHIP). Any team member that exceeds the average, while achieving 100 percent accuracy on cases denied or closed (called negatives) and 95 percent accuracy on affirmative decisions (called actives) can earn bonuses of \$10 per determination above the average, up to \$8,000 annually.

Last but not least, as touched on throughout the paper, there are a number of points at which states can collect data that will aid them in assessing and boosting the quality of consumer assistance. Many states have been thwarted in their data collection efforts by the inflexibility of eligibility systems. States that have invested in better technology have developed daily and weekly monitoring tools, often called dashboards, that track and analyze both individual worker and aggregate data, which is a helpful to both workers and supervisors. However, **tracking data** is not the end point; data can be used to identify opportunities to improve the delivery of services. The challenge for states will be setting priorities for data reporting and analysis and using data on a regular, consistent basis. Yet to be released federal performance metrics will play a key role in states' prioritization of key data elements and benchmarks. States may want to consider these metrics to be a floor, not a ceiling, and think big when it comes to data-driven management to effect customer service quality.

Conclusion

The ACA creates a new health coverage landscape that has significant and substantive implications on both staff roles and business processes for Medicaid and CHIP agencies, while establishing an operational baseline for the new health insurance exchanges. How Medicaid, CHIP and the state or federal health insurance exchange choose to integrate or coordinate services will have a tremendous impact on a consumer's experience. Collaboration, coordination and communication between all stakeholders will be key to success.

New IT systems provide states with the potential for real-time eligibility through a web-based application process that will revolutionize enrollment in public coverage and improve flexibility in the future. With the 90/10 Medicaid eligibility systems funding expiring in 2015, states are in a unique but time-limited position to finance the development of technology-based customer assistance. The robustness of the enhanced customer service tools combined with strong community-based assistance will have a critical impact on how well consumers' needs are met. As states design and implement their new systems, it is paramount that all agencies work together to create a unified vision for customer service, involving all key stakeholders in the process and keeping the lines of communication open, while they prepare staff and partners for their enhanced customer service roles.

BOX 2 – UTAH: A TECHNOLOGY LEADER IS FIRST TO LAUNCH CHAT AND E-NOTICES

In 2004, Utah was the first state to launch an electronic data brokering system (eFind) to consolidate and simplify access to different federal and state electronic data sources needed to verify Medicaid and other public assistance program eligibility. eFind cost \$2 million to build, and in its first year, delivered a return on investment of \$2.1 million in administrative savings by reducing the time required to conduct multiple data searches. eFind also saves on the cost of training workers to navigate multiple websites to access data separately.

In 2009, faced with dwindling state resources and increased demand for services, Utah consolidated its eligibility and customer services into a single division in an effort to, among other things, balance out workloads, ensure consistency across regions and workers and improve agency performance and efficiency. At that time, a team-based approach to eligibility management was adopted and eligibility workers were assigned to teams of approximately 15 workers organized by program expertise (i.e., long-term services and supports) or to support a specific population (i.e., Spanish speakers). Soon after the restructuring, the state launched eRep, an integrated rules-based integrated eligibility system supporting multiple assistance programs. Altogether, these efforts have resulting in significant reductions in average eligibility costs, improved eligibility decision accuracy rates and decreased processing times.

In late 2010, Utah released myCase, a secure customer-facing portal that allows customers to apply for and manage their benefits. A number of enhancements have already been introduced to myCase and today consumers can apply for or renew benefits, report changes, see the status of verifications, pay premiums, authorize third party access to their account, and go paperless by opting for e-notices. myCase also provides online chat support to assist consumers. (About 15% of all contacts – phone and chat – occur via chat.)

Another innovative myCase feature allows consumers to access a verification screen that displays, in real time, a list of needed verifications and their status, either received or outstanding. By clicking on the details next to missing verifications, a pop-up box allows customers to see what types of documents can be used to provide proof of eligibility. Eligibility workers can write customized messages in the verification details box (for example, requesting a pay stub for a specific date), a feature that saves multiple phone calls to clarify missing documents.

myCase allows customers to opt to go paperless by electing to receive up to four types of communications electronically: notices, renewal requests, premium reminders and interview requests. When notices are posted in the consumer's online account, an alert is sent via e-mail, text message or both, based on the customer's preferences. myCase's features have proven popular; nearly two-thirds of beneficiaries (63%) have established an online account. Of those, 39 percent have opted to go paperless (as of March 2012), a statistic that is increasing by an average of two percentage points each month.

BOX 3 – NORTH CAROLINA: COLLABORATING WITH COUNTIES TO DELIVER HIGH-QUALITY CONSUMER ASSISTANCE

When the ACA became a reality, North Carolina already was moving forward with its new integrated eligibility system and online application, called NC FAST (Families Accessing Services through Technology). Similar to the goals of the ACA, their intent was to simplify and streamline their eligibility process for all public assistance programs through the use of high-performing technology.

North Carolina's vision for service delivery includes these foundational tenets:

- Families will tell their story once and receive the services they need.
- There will be no wrong door to accessing benefits. Clients will have a choice in when, where and how they access benefits.
- Community partners will provide new avenues for accessing services.
- The state and counties will work together to improve operations, maximize technology and make the service delivery system as efficient as possible.
- Customer service, efficiency and data will drive the development of service delivery models and the development of staffing roles.
- Counties will retain flexibility in implementation, but outcomes, performance and a positive customer experience will be the ultimate measures of success.
- Accessing benefits will not be a hindrance to working families and individuals.

North Carolina is quick to give credit to other states, from which they have drawn creative ideas and best practices to develop a strong customer-focused vision for moving forward. In turn, states with county-based systems may want to follow their progress and borrow their concepts in implementing the ACA.

State officials note that North Carolina counties, which underwrite a high proportion of their administrative costs, experienced a flood of demand for services and were struggling to keep their heads above water during the recession. The extent of the economic downturn, bringing in record numbers of new families well beyond cyclical demand, offered a glimpse of what the ACA's coverage expansion might bring. These circumstances created a readiness for change but the state's strategy of engaging counties in the planning process was also a critical step in soliciting ideas and getting buy-in to the changes ahead. A key to their success is the flexibility that counties have to achieve the intended results, contingent on meeting specific benchmarks such as determining eligibility for 75 percent of families within 24 hours.

Going forward, North Carolina has a comprehensive plan for communications that will include a formalized structure of communication and feedback between the state, key stakeholders and the counties. A targeted communication plan will reinforce key messages to county commissions, county boards, community partners, clients, the general public, with a special emphasis on county and state staff at all levels.

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Notes

¹ Pamela Farley Short, Katherine Swartz, Namrata Uberoi & Deborah Graefe, “Realizing Health Reform’s Potential: Maintaining Coverage, Affordability and Shared Responsibility When Income and Employment Change,” Commonwealth Fund, May 2011.

² Stacey McMorro, Genevieve M. Kenney, Christine Coyer, “Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas,” The Urban Institute, May 2012.

³ Under new regulations issued at 42 CFR 435.908 (a), the agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with §435.905(b) of this subpart. CMS has indicated that it will be issuing sub-regulatory guidance on consumer assistance.

⁴ Alice Weiss, Laura Grossman, “Paving an Enrollment Super Highway: Bridging State Gaps Between 2014 and Today,” National Academy for State Health Policy, March 2011.

ABOUT MAXIMIZING ENROLLMENT

This issue brief is a product of *Maximizing Enrollment: Transforming State Health Coverage*, which is a \$15 million, four-year initiative of the Robert Wood Johnson Foundation (RWJF). Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, *Maximizing Enrollment* aims to help states transform their eligibility and enrollment systems to improve enrollment and retention of individuals who are now eligible for Medicaid and the Children’s Health Insurance Program (CHIP), and to prepare to enroll newly eligible individuals and families in public and publicly subsidized health coverage. By helping selected states improve their systems, policies and procedures — and measure the impact of these changes — RWJF hopes not only to increase the efficiency and effectiveness of these programs in enrolling and retaining those eligible, but to share knowledge about what works to increase enrollment and retention within public and publicly subsidized health coverage in all states.

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⁵ Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, Jessica Stephens, “Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Procedures, and Cost-Sharing Policies,” Kaiser Commission on Medicaid and the Uninsured, January 2012.

⁶ 45 CFR 155.205.

⁷ §1902(a)(19) of the Social Security Act currently requires states to provide assistance with the application or redetermination process. §1943(b)(1)(F) of the Social Security Act currently requires states to conduct outreach to vulnerable and underserved populations. §42 CFR 435.908(b) states that the agency must provide assistance to any individual seeking help with the application or redetermination process in person, over the telephone, and online and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

⁸ Based in data provided by the Oklahoma Health Care Authority, June 2012.

⁹ According to the Georgetown and Kaiser 50-state survey, 32 states now have web-based applications with electronic for Medicaid and CHIP.

¹⁰ Shelby Gonzales, Samantha Artiga, “Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement,” Kaiser Commission on Medicaid and the Uninsured, June 2011.

¹¹ *Ibid* 10.

¹² Lindsey J. Leininger, Donna Friedsam, Kristen Voskuil, Thomas DeLeire, “The Target Efficiency of Online Medicaid/CHIP Enrollment: An Evaluation of Wisconsin’s ACCESS Internet Portal,” State Health Access Data Assistance Center at the University of Wisconsin, February 2011.

¹³ Kathryn Zickuhr & Aaron Smith, “Digital Differences,” Pew Research Center, April 2012.

¹⁴ *Ibid*.

¹⁵ Julie Silas & Christina Tetreault, “Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage?,” Consumers Union, November 2011.

¹⁶ “Continuing the Progress: Enrolling and Retaining Low-Income Families in Health Care Coverage,” The Department of Health and Human Services, Centers for Medicare and Medicaid Services, August 2011.

¹⁷ Data provided by Rebecca Mendoza, Director of the Division of Maternal and Child Health, Virginia Department of Medical Assistance Services for new application and renewal data for the period of July 2012- April 2012”

¹⁸ *Ibid* 16.

¹⁹ Interview with Alabama Medicaid and CHIP officials, March 2012.

²⁰ NASHP also plans to release a larger brief dedicated to the topic of navigators in the near future.

²¹ *Ibid* 18.

²² Laura Summer & Cindy Mann, “Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies,” The Commonwealth Fund, June 2006.

²³ *Ibid* 5.

²⁴ Tricia Brooks, “The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP,” Georgetown University Center for Children and Families, February 2009. This paper reports updated statistics received directly from Louisiana’s Medicaid agency.

²⁵ *Ibid* 18.

²⁶ *Ibid* 5. In 2012, 14 states allow children’s coverage to be renewed over the phone in both Medicaid and CHIP, while 19 states offer online renewals for both programs. A total of 22 states offer telephone renewals in either Medicaid or CHIP, while a total of 23 states allow enrollees to renew online in either Medicaid or CHIP.

²⁷ Exchanges must have an “active authorization” on file to request tax data on behalf of an enrollee. Such authorizations are effective for no more than a five-year period. If the authorization is not active, the exchange will need to obtain such authorization prior to seeking data to automatically determine only going eligibility. (§155.335(k)).

²⁸ 45 CFR 155.335 establishes annual redetermination requirements. This exchange must have an authorization on file to access an enrollee's tax data (as described in note 27 above), which can be in effect for up to five years. Enrollees are required to report changes and are asked to sign and return the form. However, if the enrollee does not respond, the exchange must redetermine eligibility based on the information available to it and the enrollee will remain in the same QHP as the previous year.

²⁹ Ibid 1. Based on the 2004 Survey of Income and Program Participation, the study concluded that 17% of the families qualifying for exchange coverage with incomes between 133% and 200% FPL experienced a drop in income below 133%, which would qualify them for Medicaid; while 24% in the Medicaid income range had increases in income that would qualify them for the exchange.

³⁰ 12-month continuous eligibility is a policy option that states may voluntarily adopt for children in Medicaid and CHIP. The preamble of the Medicaid regulations implementing the ACA suggests that states might apply for §1115 waiver authority to provide 12-months continuous eligibility to adults, as has been approved for the state of New York.

³¹ Based on the author's experience in managing New Hampshire's CHIP program from 1998 until 2008.

³² 45 CFR 155.420(b).

³³ "Washington State Health Benefit Exchange: Potential Role and Responsibilities of Navigators," draft report available for public comment at http://www.hca.wa.gov/hbe/documents/policy/HBE_Policy_Navigator_Paper_Draft.pdf.

³⁴ Lake Research Partners, "Preparing for 2014: Findings from Research with Lower-Income Adults in Three States, Robert Wood Johnson Foundation, June 2012.

³⁵ For more information, see <http://www.ux2014.org>. The eleven states participating in Enroll UX 2014 are Alabama, Arkansas, California, Colorado, Illinois, Massachusetts (with Maine, Rhode Island, and Vermont in a consortium), Minnesota, Missouri, New York, Oregon and Tennessee. Each state has assembled a cross-disciplinary project team that is participating in all stages of the design journey.

³⁶ Ibid 5.

³⁷ Ibid 35.

³⁸ Carol Volk, "RightNow Guide: Best Practices for Chat Deployments," 2010," RightNow Technologies; based on Forrester Research studies.

³⁹ "Chat Customer Service: Eight Steps to Success," Cisco, 2011.

⁴⁰ Elizabeth Boehm, Maria Dorsey, Elisabeth L. Bocal, "Case Study: Regency Uses Chat to Boost Customer Satisfaction, What Customer Experience Professionals at Other Firms Can Learn," Forrester Research, Inc. February 2011.

⁴¹ Based on author's review of state exchange IT requests for proposals.

⁴² Geoff Williams, "Turning Abandoned Shopping Carts into Sales", CNNMoney.com, June, 2010

⁴³ Utah presentation at Maximizing Enrollment meeting, May 2012.

⁴⁴ 45 CFR 156.230(b).

⁴⁵ Vicki Grant, "Transforming State Government Services Through Process Improvement: A Case Study of Louisiana, The IBM for The Business of Government", 2010.

⁴⁶ Interview with Louisiana Medicaid officials, March 2012

⁴⁷ Interview with Oklahoma Health Care Authority officials, March 2012

⁴⁸ Dan Fox, "Consumer Study Finds Overwhelming Dissatisfaction with IVR", July 2011, Interaction Corporation; based on a study by Liel Leibovitz, New York University.

⁴⁹ Arizona HIX IVR requirements document.

⁵⁰ 45 CFR 155.210(b)(2)(i).

⁵¹ "Oregon Health Insurance exchange: Overview and Frequently Asked Questions," Oregon Health Insurance exchange Board Materials, April 12, 2012.

⁵² Jocelyn Guyer, Tricia Brooks, Samantha Artiga, "Secrets to Success:" An Analysis of Four States at the Forefront of our Nation's Gains in Covering Children," Kaiser Commission on Medicaid and the Uninsured, January 2012.

⁵³ Work Support Strategies is a grant funded learning collaborative that supports a select group of states in designing, testing, and implementing more effective, streamlined, and integrated approaches to delivering key supports for low-income working families, including health coverage, nutrition benefits, and child care subsidies. For more information, see <http://www.urban.org/worksupport/>.

⁵⁴ John Jones, DeAnne Aguirre, Matthew Calderon, “10 Principles of Change Management,” Booz & Co., 2004.

⁵⁵ Ibid.

⁵⁶ Ibid 54.

⁵⁷ Ibid 25.

⁵⁸ Ibid 47.

⁵⁹ With funding from the Robert Wood Johnson Foundation (RWJF) for its Covering Kids and Families Initiative, two state learning collaboratives were convened: the Medicaid Eligibility Process Improvement Collaborative and the Medicaid and CHIP Retention Initiative. RWJF also supports the Maximizing Enrollment Initiative. Process improvement has been an integral part of each of these collaboratives.