Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Robert Wood Johnson
Foundation

APRIL 2016

Making Medicaid Work Better: Lessons from States on Implementing Ex Parte Renewals

By Tricia Books, MBA and Eugene Lewit, Ph.D

Support for this report was provided by a grant
from the Robert Wood Johnson Foundation

Authors

Tricia Brooks, MBA
Associate Research Professor
Georgetown University Health Policy Institute

Senior Fellow
Georgetown University Center for Children and Families

Eugene Lewit, PhD
Consulting Professor
Stanford University
Department of Health Research and Policy

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve health coverage for America's children and families.

As part of the University's McCourt School of Public Policy, Georgetown CCF provides research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP) and the Affordable Care Act.

Introduction

In addition to expanding Medicaid's role as a key source of health coverage for low-income individuals, the Affordable Care Act (ACA) has been a catalyst in moving states to modernize the administration of their Medicaid programs. A clear goal of the law is to accelerate the use of technology to streamline enrollment, promote retention, and provide seamless coordination among coverage options. The law is intended to help enhance the consumer experience and improve administrative efficiency by replacing paper-driven, manual procedures with automated processes that rely on high-performing eligibility and enrollment systems and linkages to reliable electronic data sources to verify eligibility. How the law is implemented will determine how well it meets this goal.

A specific focus of the ACA is to maximize ongoing coverage and reduce the likelihood that eligible enrollees become uninsured due to procedural or paperwork reasons at renewal. Even relatively short coverage gaps can disrupt access to care, are administratively inefficient, and inhibit efforts to measure the quality of health care.[1] Studies have shown that the process for recertifying ongoing eligibility at renewal is the most significant threat to continuous coverage.[2] To address this problem, the ACA calls for states to renew coverage every 12 months, but no less frequently, and replace outdated paper renewal processes with electronic processes that can promote retention. (For detailed information on the federal rules regarding the renewal and verification process, see the Appendix.)

Efforts to transform the renewal process took a backseat to other challenges states faced when new systems and processes were first launched in late 2013 to support the ACA's expanded coverage options. After many states postponed renewals and delayed implementing new renewal procedures during 2014, they took up this task in 2015.[3]

This brief focuses on states' experiences in implementing data-driven renewals in Medicaid through a process called '*ex parte*' – using third party data sources to confirm ongoing eligibility. We interviewed officials in eight diverse states[4] to identify the challenges states face in automating the renewal process and summarize their experiences in overcoming these barriers to achieve high rates of ex parte renewals. The authors also drew on their deep knowledge about the state processes and input from stakeholders who are familiar with the federal rules and have first-hand experience with how implementation of data-driven renewals is playing out in the states.

Report

What is an 'ex parte' renewal?

The use of third party data sources to determine eligibility is not new but the ACA puts greater emphasis on it by requiring states to conduct ex parte reviews of eligibility before sending renewal forms. This proactive approach builds on other streamlining measures in the ACA that move Medicaid from reliance on manual paper processes by harnessing technology and accessing electronic data sources to determine eligibility at application and renewal.

Based on a current working definition from the Centers for Medicare and Medicaid Services (CMS), "an ex parte renewal – also known as auto renewal, passive renewal, or administrative renewal – is a redetermination of eligibility based on reliable information contained in the beneficiary's account [enrollee's case record] or other more current information available to the agency, including information accessed through electronic data sources."[5] This definition reflects several options for implementation, but a key distinction in defining ex parte renewals is that it happens without beneficiary involvement.[6]

One approach is to electronically cross-check enrollee information with data from reliable sources to gather current income and other information that may impact ongoing eligibility. States may also conduct ex parte renewals via express lane eligibility based on information from other means tested programs[7] or using the targeted renewal strategy that relies on data collected by the Supplemental Nutrition Assistance Program (SNAP).[8] States may also take a different tack by analyzing historical case data to identify circumstances that with reasonable certainty should qualify the enrollee for automatic renewal, such as

coverage for a child living with a guardian whose income does not count toward the child's eligibility. Some states use more than one approach.

When attempting to verify income reported by an applicant or enrollee, it is important to recognize that data secured from the electronic data sources are unlikely to result in a precise match. When differences in income are inconsequential to the eligibility determination – that is, the income reported by the individual and the income secured from the data source are both below the Medicaid eligibility threshold – they are considered 'reasonably compatible' and the individual is determined eligible for Medicaid. While ex parte is not new, applying a reasonable compatibility standard to account for differences in reported income is. Moreover, states have the option to establish a broader reasonable compatibility standard to account for situations when the self-reported income is above Medicaid eligibility but the data source is below Medicaid eligibility, and vice versa. (For examples of how reasonable compatibility works, see the Appendix).

What is the current status of state implementation of ex parte renewals?

All states are required to implement ex parte renewals, starting with individuals enrolled in income-based Medicaid categories (also known as MAGI for Modified Adjusted Gross Income), which includes children, pregnant women, parents, and low-income adults in states that have expanded Medicaid. Eventually these policies will apply to all Medicaid groups. In an annual survey of state policies, 34 states reported that as of January 2016 they were able to process automated renewals for MAGI-based eligibility groups using information from electronic data sources. Of those, 26 reported the share of renewals for which ongoing eligibility was determined via ex parte. Ten of the 26 states reported they are automatically re-determining eligibility at renewal for more than half of MAGI enrollees.[9] (See the figure.)

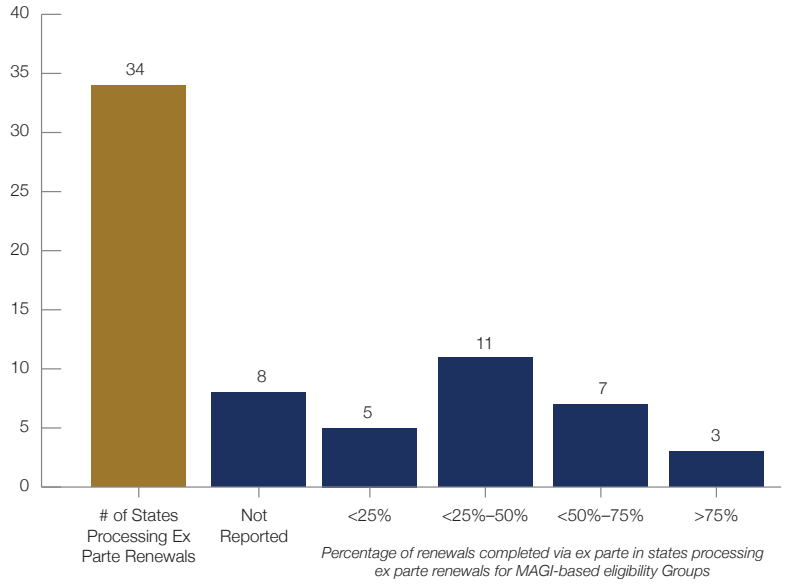
Clearly states are making notable gains in implementing ex parte processes. However, without data from all states on the share of ex parte determinations, it is not possible to identify when states report the 'ability' to conduct ex parte renewals but use it sparingly. At this stage of implementation, it is also difficult to get a good sense of the extent to which ex parte processes are handled automatically (often called 'no-touch' determinations) versus being triggered through manual intervention by eligibility workers. Ultimately, the goal for ex parte renewals (as well as real-time, data-driven eligibility determinations on new applications) is to develop highly efficient, automated methods.

What are the top takeaways from our interviews with state officials?

These highlights reflect the overarching insights we extracted from interviews with state officials.

- **Different definitions of ex parte** – It was clear from the interviews with state officials that there are different interpretations of what constitutes an 'ex parte' renewal, and some states may equate ex parte renewals with data-driven renewals. While states may be using electronic data sources to verify eligibility when enrollees report changes or return renewal forms, the critical test for a true ex parte renewal is – *"was eligibility renewed without the enrollee having to take any action or submit paperwork?"* The differences in interpretation suggest that, as in the figure below, when states are asked if they are conducting ex parte renewals, an affirmative answer may not mean that the state is doing it in a way that meets the critical test. In order to accurately determine which states are successful in conducting ex parte renewals, and to assess what share of renewals are determined on an ex parte basis, it will be important to promote a common definition of the term.
- **Unclear or conflicting federal guidance** – States express frustration over what they describe as unclear or conflicting federal laws, regulations, and guidance. One example is the different ways in which cross-referenced data is determined to be reasonably compatible. In the new Health Insurance Marketplaces, eligibility is based on the enrollee's projected income – that is, what he expects to earn in the upcoming tax year. If the self-reported projected income is no more than 10 percent lower than the individual's most recent tax return, it is accepted without triggering a request for documentation. However, reasonable compatibility in Medicaid works differently. If the income reported by the applicant and income from the data source are both below the Medicaid threshold, regardless of how large the difference, the individual is determined eligible for Medicaid. (For more information on reasonable compatibility, see the Appendix.)
- **Technological challenges** – State officials describe a variety of technology related barriers to achieving a streamlined renewal process. To start, many states had

Status of State Implementation of Ex Parte Renewals In Medicaid



Source: Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-sharing Policies: Findings from a 50-State Survey, Kaiser Family Foundation and the Georgetown Center for Children and Families, January 2016

to adjust to a new paradigm in which policy drives system design and functionality, which was in stark contrast to years of dealing with inflexible systems that made it difficult or impossible to update policies and procedures. Interviewees reflected on the difficulty of developing specifications for untested business processes that existed only in regulation and not in practice. States that operate their own state-based Marketplaces (SBMs) note that integrated Marketplace/Medicaid systems are designed to address the needs of the Marketplace, not Medicaid. Thus, after the initial eligibility determination, some SBM states manage their Medicaid cases and process renewals outside their primary integrated eligibility service. States with decades-old Medicaid mainframe computers or "legacy" systems report the inability to transfer existing enrollment data into new MAGI-based Medicaid systems or the integrated Marketplace system. This proved especially cumbersome for the first round of renewals and delayed implementation of ex parte reviews.

- **ACA implementation a heavy lift** – States had less than four years to prepare for the launch of the ACA's coverage options and implement new eligibility and enrollment rules that significantly transformed Medicaid. Importantly, many unexpected events diverted their attention and resources from Medicaid, including political challenges to the law, delayed regulations and guidance, and significant technological problems in both implemention and coordination with the new federal or state-based Marketplace systems. In the end, ACA implementation proved far more complex than expected for state Medicaid agencies as they were tasked with multiple priorities. Collapsing Medicaid eligibility groups; converting pre-ACA eligibility levels to new MAGI standards to incorporate disregards and deductions; developing hospital presumptive eligibility programs; deploying new single, streamlined applications; opening up multiple consumer channels for enrollment and renewal; troubleshooting account transfers between Medicaid and the federal Marketplace; and putting out the welcome mat for a flood of new enrollees were among the many transformative actions expected of states in addition to deploying new systems and implementing data-driven eligibility determinations at application and renewal. Given that renewal is a downstream process that occurs after application, eligibility determination, and enrollment, ex parte renewals took a backseat to other critical tasks.
- **Culture change** – State Medicaid officials reflected on the continuing need to work on culture change within the agency that administers eligibility, which is often the human services agency, not the Medicaid

agency. Changing agency culture – that is, staff perceptions, attitudes, and established ways of doing things – is one of the toughest tasks in transforming Medicaid. Historically, some administrators and eligibility workers have believed it is their job to divert people away from public assistance.[10] Heavy reliance on automated determinations – eligibility decisions made by systems without a human touch – can raise concerns about program integrity. Eligibility workers may feel overwhelmed as enrollment grows and their workload shifts from a mix of cases to a focus on the more complex cases that cannot be determined automatically and are difficult to untangle. Change is hard and requires active, well-informed, and committed leadership within an agency to set the tone.

- **More opportunities to learn from other states** – A recurring theme that emerged during interviews with state officials was the desire for more collaboration and sharing of experiences among states. The context of these comments went beyond exchanging policy language and interpretation to a desire for a more in-depth focus on state processes and how states have solved problems. Access to a set of lessons learned from states that have successfully addressed issues, as well as direct interaction with states continuing to work on implementation, were at at the top of most states' wish lists.
- **Funding and data-sharing agreements no longer top the list of barriers.** While deploying high-performing IT systems has proven demanding to states, funding for these systems is no longer the barrier that it was when states held on to outdated systems for decades due to cost. Since the ACA was enacted, CMS has permanently implemented enhanced federal funding – 90% for development and implementation; 75% for ongoing maintenance and operations – to support state acquisition and operation of upgraded or new systems.[11] Additionally, executing formal data sharing agreements between agencies to access useful electronic data, while sometimes still a challenge, was not highlighted as a significant problem. Interviewees did acknowledge that differing priorities across agencies can slow progress and that getting the automated interfaces working well can be challenging despite cooperation among agencies. Several states cited the importance of strong executive leadership to articulate a vision for health reform and set the expectation that all appropriate agencies collaborate on implementation.

What data sources have proved useful or not in confirming ongoing eligibility through the ex parte process?

Generally, states verify fewer eligibility criteria at renewal than for new applications since there is no need to re-verify criteria that would not be subject to change, such as a social security number or date of birth. Although most states accept self-attestation for state residency and household composition, the states that verify these criteria would also validate changes at renewal.[12] States may also check death or incarceration records and re-verify qualified immigration statuses that could be subject to change. In general, however, eligibility verification at renewal is focused predominantly on income. (For more information on verification requirements, see the Appendix.)

States are using a variety of data sources to verify income and other eligibility criteria that may have changed. Sources include the federal data services hub that provides access to data from the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and a commercial source of employment and wage information. With the exception of IRS data, states may prefer to access these sources through mechanisms that existed prior to the creation of the federal hub. In addition to federal sources, almost all states access state wage and unemployment compensation databases, while some states use state income tax data and relevant data from other means-tested benefit programs such as SNAP.

States are required to rely on electronic data "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual."[13] To this point, it was clear from the interviews that states have differing perspectives on the usefulness of different data sources and there is no clear consensus on best sources of data. To some extent, state perceptions about various data sources depend on their understanding of federal flexibility and agency philosophy regarding verification. Some states – more often those with state-based Marketplaces – rely primarily on the federal hub while others say that IRS income information through the hub is the least useful for Medicaid because it does not reflect current income. States also noted that the federal hub is not always the best source for handling the detailed

Differences in States' Perspectives on Updating Data Lead to Different Renewal Processes

Although interviews with state officials revealed certain consistencies in practice and procedures, one area of variation was in the process steps and amount of information states request at renewal. The differences generally reflect contrasting state perspectives and experiences. Two ends of the spectrum are described below but there are a variety of practices that fall between.

When states can successfully determine eligibility via ex parte, they are only required to send a notice of ongoing eligibility.[22] Yet, on one end of the spectrum, two of the states interviewed send pre-populated renewal forms to every MAGI enrollee who is coming up for renewal, even those for whom they have sufficient information to make the ex parte determination. The forms include all the relevant information known to the state including updated information from recent electronic data matches. The beneficiaries are asked to return the forms, within a specified time limit, if the information is not accurate. If the enrollee does not respond, the information gathered through the ex parte process is used to make the eligibility determination. This meets the standard of ex parte – meaning ongoing eligibility can be determined without action by the enrollee. States that follow this procedure report that it ensures that all case-related information is up-to-date and not just information that affects eligibility.

At the other end of the spectrum, several states followed a streamlined ex parte process. In those states, enrollees who were found eligible based on an electronic data match were simply sent a notice of renewed eligibility. These states expressed concern over the cost of printing and mailing multi-page pre-populated forms (the CMS model renewal form is 13 pages long). Additionally, they point out that enrollees tend to wait until the last minute and return forms (as they are accustomed to doing) even if there are no changes. This creates significant work on the part of the agency to review returned forms and can result in backlogs. These states also note that many enrollees are not yet taking advantage of online features that would help automate the process, rather than requiring eligibility staff to manually update information.

There are a variety of practices that fit between the two ends of the spectrum. States may send prepopulated forms along with the renewal notice asking for updated information if something has changed. For individuals who cannot be renewed on the basis of an automated data match, states are expected to send pre-populated forms requesting needed information, although only 80 percent of states have implemented these forms.[23] For enrollees not renewed via ex parte, some states request only the data needed to complete the renewal. Others request additional data elements and send enrollees a "full eligibility package," asking them to update all the information in the Medicaid eligibility system. Regardless of how states currently handle renewals, procedures and processes will continue to evolve over time as states make additional system enhancements and gain experience in conducting ex parte renewals.

information needed to confirm qualified immigration statuses for Medicaid eligibility.

What advice do states offer to overcome challenges to implementing ex parte renewals?

States found no silver bullets in developing their new systems and overcoming challenges in implementing the ex parte renewal process. Comments such as "it will be painful for a while" and "it takes perseverance" reflect the reality that designing and deploying new technology-based processes is tedious and time-consuming work. In some regard, it was difficult for interviewees to isolate their comments to ex parte renewals. Thus, their advice (below) may have broader applicability to using technology to replace manual processes and streamline enrollment and renewals:

- **Get the horsepower in-house to manage vendors.** States find high value in hiring in-house information technology (IT) experts with proven track records in managing vendors, who often overpromise and under-deliver. States recommend assigning contract management and oversight responsibilities to IT experts, even if policy and operations staff working directly with the vendors on design, development, and deployment have contract management experience.
- **Pick the right implementation team.** System development is tedious work and requires patience, perseverance, and problem-solving skills. Some of the most knowledgeable policy experts may not have those attributes, or may be resistant to change. Drawing on staff that has a higher comfort level with technology and openness to change may be a successful strategy.[14]

- **Involve high-level decision-makers on the implementation team.** When decisions are needed quickly but require higher-level approval, states will lose time if key leaders with decision-making authority are not kept abreast of the rapidly changing status of system development.
- **Do not hand off the design, testing and troubleshooting to vendors.** Although using experienced vendors can be an advantage, states cautioned that design, testing and troubleshooting of the system should rest in the hands of knowledgeable state policy and operations staff and not be handed off to vendors or IT staff. Vendors promote work they have done elsewhere and express confidence in knowing what to do but may not appreciate the nuanced differences in state policies and interconnected systems. Also, vendors may have stretched their own capacity and expertise in ramping up to meet increased demand for services across the country.
- **Get the details of the design right on paper before building the system.** Despite the fact that it may take longer to get started, upfront time spent in finely detailing business design documents and work specifications will pay off in greater likelihood of getting it right the first time. Change orders are costly, and vendors will charge extra even when they are the source of inaccurate advice to states. States report that using knowledgeable workgroups to develop "what if" scenarios and identify how things work with current and new policies and procedures is a useful exercise.
- **Policy should drive the system rather than the system limiting policy.** Vendors can make it sound difficult and costly to implement needed functionality. Consequently, without detailed business design documents and clear guidance on policy upfront, there is a strong likelihood that system performance will be inadequate and fixes will be more costly down the road.
- **When working across agencies, find the right person in the agency that manages the data you need.** Doing so will facilitate cooperation and assist in identifying the technical experts who can understand what data is needed, ensure that the correct information is exchanged, and assist in interpreting the returned data in a meaningful way.
- **Break down implementation into manageable chunks.** When system functionality is phased in, it is easier to test and troubleshoot problems. For example, integrate one data source at a time or phase in online account features to make sure the system is working as expected before moving on. A key lesson learned from the days of legacy systems is that creating "workarounds" – rather than making system changes to accommodate updated policy or correct errors at the source – only compounds the problem.
- **Take the time to conduct robust testing before the system is launched.** Identifying and correcting glitches prior to launch is an important step that should not be short-changed. After the system goes live, states will find it helpful to conduct case audits and solicit feedback from application assister networks and other stakeholders to pinpoint and troubleshoot problems not uncovered during the testing phase.
- **Cultivate culture change.** Staff attitudes and perceptions including a resistance to change, lack of confidence in electronic processes and data, and concern about eligibility determination errors can inhibit progress. States recommend preparing staff for the fact that workloads may increase (at least in the short run) and that the mix of work will change as eligibility staff are tasked with unravelling complex cases. Interviewees suggest that states can manage and promote culture change by crafting a compelling vision of the goal and engaging all levels of staff in the planning and execution of new processes.[15]
- **Do not launch major system enhancements during open enrollment.** The increased application volume during open enrollment makes it more difficult to allocate staff time and resources to testing and troubleshooting new functionality.
- **Engage advocates and consumers in system development.** In the design phase, advocacy groups and other stakeholders can help identify "what if" scenarios. They can be particularly helpful in communicating information about new policies and processes to the public and building support for system reform. They should also be tapped, along with consumers, as a fresh set of eyes when testing the system. Importantly, external

stakeholders, and specifically consumer assisters, can serve as key resources in spotting possible barriers and providing feedback on how implementation is affecting real people.

What steps are states taking to increase the share of renewals that are automated?

Some states use internal teams to analyze the types of cases that are not automatically renewed to identify common bottlenecks and help brainstorm potential solutions. Getting feedback from application assisters and other community organizations that are knowledgeable about policy and understand how processes are impacting consumers can also yield valuable information. Both of these activities may lead to solutions that could sweep more renewals into a true ex parte process.

States that use alternative processes – such as express lane eligibility, the SNAP renewal strategy, or the identification of cases unlikely to have a change in eligibility (as noted above) – suggest that these processes are highly effective and could be useful, in addition to or as a primary mechanism, in fulfilling the requirement for ex parte renewals.

What other policy options or steps can states take to improve retention and minimize gaps in coverage?

- **Implement 12-month continuous eligibility.** Although the ACA requires that states renew MAGI-based Medicaid groups no more frequently than once every 12-months, enrollees are expected to report changes that may impact their eligibility unless the state has specifically adopted 12-month continuous eligibility as a policy option. Continuous eligibility allows individuals to remain enrolled for a full year regardless of changes in income or household size. Almost half of the states (24) have adopted this policy for children in Medicaid while three quarters of separate CHIP programs (27 of 36) provide 12-month continuous eligibility. States may cover parents and adults continuously for 12 months through Section 1115 authority, which New York and Montana have taken up since 2014.[16]
- **Embrace flexible options in verifying eligibility.** Optional policies, such as accepting self-attestation of certain eligibility criteria or applying broader reasonable compatibility standards, may lead to higher ex parte success rates. CMS can be a resource for states in clarifying where flexible policies exist and how other states have approached implementation. (For more information on reasonable compatibility standards, see the Appendix.)
- **Improve notices to enrollees.** The combination of health insurance information and eligibility for public programs is complex to communicate. The use of plain language and clear instructions when action is needed are critical to ensure effective communication with enrollees. Engaging external stakeholders in the process of simplifying notices and conducting consumer message-testing have proven effective in ensuring that notices are easy to understand. Notices should also be translated into the preferred language of enrollees, and minimally for languages spoken by 5% or 1,000 individuals in the entity's service area.[17] Adding taglines in multiple languages is also useful in connecting enrollees with oral interpretation services.
- **Send renewal reminders.** When states are unable to determine ongoing eligibility via ex parte, they must provide enrollees a minimum of 30 days to provide information needed to re-determine eligibility at renewal. Experience has shown that follow-up reminders by phone or mail contribute to higher returns of renewal forms.
- **Find ways to increase consumer use of online tools.** Although it is unrealistic to expect that all applicants and enrollees have access to or are comfortable with using online functions, it is important for states to identify ways to increase the use of web-based tools. Suggestions include developing mobile applications, promoting the use of online functions on forms and in automated phone messages, and creating easy-to-understand guides to help consumers navigate the systems. Increased consumer use of online capabilities will pay off in administrative efficiencies.[18]
- **Improve coordination among coverage options.** Some enrollees will no longer be eligible for Medicaid or CHIP at renewal; however, many of these individuals will be eligible for financial assistance to purchase a qualified health plan in the health insurance Marketplaces. Although efforts to improve the account transfer process between coverage sources is ongoing, more work is needed to validate that states are appropriately transferring the account information

to the Marketplace for all individuals denied or losing Medicaid or CHIP coverage.

- **Assess and minimize gaps in coverage.** Researching when and where gaps in coverage exist can be a useful exercise for states to identify opportunities to assure continuous enrollment. For example, many states provide only a 10-day notice prior to disenrollment, which is a tight time frame for individuals to take action to secure documents or seek other coverage. Strategies to reduce gaps in coverage may include adopting a longer notice period, extending eligibility to the end of the month, improving the communication of options for those who are losing coverage, and providing direct consumer assistance to disenrollees.
- **Reinstate coverage retroactively for enrollees who respond during the 90-day reconsideration period.** States must reconsider eligibility for enrollees who lose coverage at renewal but provide needed eligibility information within a required 90-day reconsideration period without requiring a new application.[19] However, they have the option to re-enroll these individuals going forward versus retroactively reinstating coverage. Retroactive reinstatement would eliminate gaps in coverage that may have resulted from procedural or paperwork reasons.
- **Engage community-based organizations, providers, and plans.** Over the years, states have found that engaging partners in reaching out to enrollees at renewal can also contribute to higher renewal rates. Some states proactively alert providers or plans, or contract with community-based organizations to encourage and assist enrollees at renewal.[20]

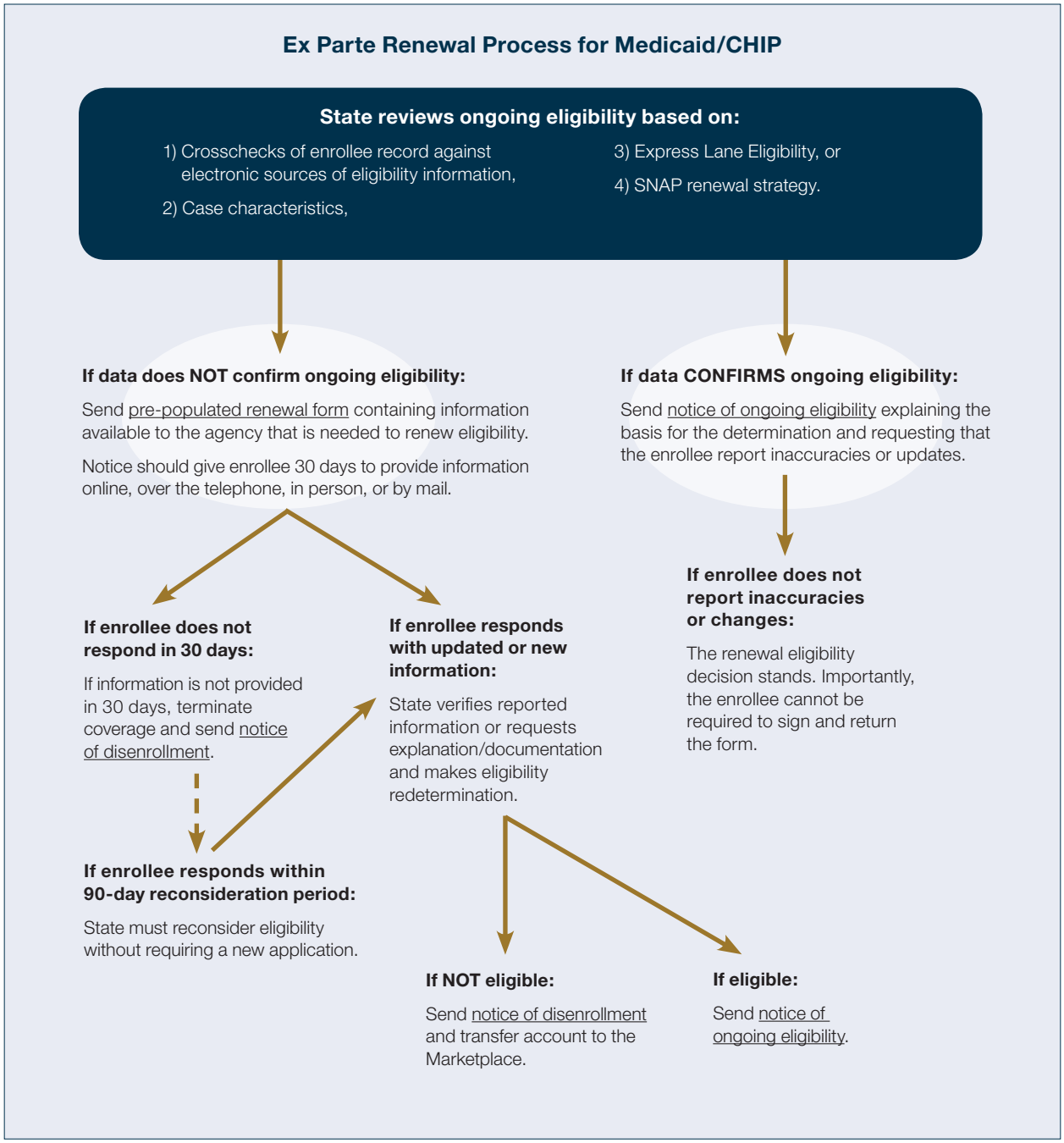
Conclusion

Leading states have shown that it is possible to renew coverage for the majority of Medicaid enrollees through automated processes. High rates of automated renewals contribute to greater administrative efficiencies, increased retention of eligible individuals, and fewer gaps in coverage and access to care. Importantly, promoting retention and eliminating gaps in coverage and disruptions in care may lead to better health outcomes and enhance a state's ability to measure the quality of health care for children and adults in Medicaid.[21]

Acknowledgements

The authors extend our gratitude to state officials in Alabama, Colorado, Idaho, Louisiana, Massachusetts, Maryland, Ohio and Rhode Island who took the time to answer our questions. We also thank our external reviewers – Jennifer Ryan, Claudia Page, and Martha Heberlein– for their helpful feedback and input. Any remaining errors are solely the responsibility of the authors.

Appendix



How is the renewal process supposed to work?

As of January 1, 2014, states must renew MAGI-based eligibility groups in Medicaid and CHIP (i.e., children, pregnant women, parents, and non-disabled adults), no more frequently than, but at least once every 12 months. Notably, states are expected to retrieve current income and other information from reliable electronic data sources to verify ongoing eligibility and automatically renew coverage whenever possible without requiring the enrollee to complete forms or provide paper documentation. If information from these sources reflects ongoing eligibility, the state must send a notice to that

effect. Enrollees are required to report any changes but cannot be required to sign and return the forms if the information on file is accurate and up-to-date.[24]

When states are not able to make a determination of ongoing eligibility automatically, they must pre-populate a renewal form or notice with relevant information and provide enrollees with a minimum of 30 days to verify or correct the information through multiple channels: online, over the phone, in person, or by mailing in paper forms. If the state can verify the updated information provided by the enrollee, the state makes an eligibility determination based on the revised data and notifies the enrollee of the decision. If the state cannot verify the updated information, it may accept a reasonable explanation or ask the enrollee to provide documentation. If the enrollee does not respond to the request for additional information within 30 days, the enrollee will be disenrolled. Under federal rules, states must reconsider eligibility without requiring a new application if needed information or documentation is submitted within 90 days of the disenrollment.

What are the federal requirements regarding eligibility verification?

The Social Security Act has long required states to have in effect an income and eligibility verification system (IEVS) to validate eligibility for public benefit programs.[25] Specifically, these systems must access wage, income, and other information from the SSA and IRS, as well as from agencies that administer state unemployment compensation and collect quarterly wage reports from employers. States must verify citizenship or qualified immigration status prior to enrollment through the SSA or DHS.[26]

States must also verify income but have the option to enroll based on the applicant's reported income and validate financial eligibility post-enrollment. States have greater flexibility in verifying other aspects of eligibility criteria including accepting self-attestation for age, state residency, and household size. At renewal, the state should not re-verify criteria that would not change, such as date of birth, or has not changed, such as the same address. Generally, this means that income is the primary criteria that must be verified at renewal, although qualified immigration status could also change over time.

What is reasonable compatibility?

Reasonable compatibility is a new federal standard that defines when differences in income are inconsequential to the eligibility determination. Recent federal regulations set minimum standards that when self-reported income and income from the data source are both above, at, or below the Medicaid threshold, the data are considered reasonably compatible without regard to the amount of the difference.[27] For example, 138 percent of the 2015 federal poverty level (the cutoff for Medicaid for many adults) for a household of one is $1,354 monthly. If an individual reports income of $1,250 but the data source shows income of $1,300, both are under the eligibility cutoff and are considered reasonably compatible.

All states must apply the federal standard, but they also have flexibility to establish their own reasonable compatibility standards when the self-reported income is above but the data source shows income below the eligibility threshold, or vice versa. About two-thirds of the states have established such standards.[28] A number of these states set a reasonable compatibility standard of 10 percent when self-reported income is below the data source but the electronic source is above the eligibility cutoff. In these cases, if the difference between the two sources is less than 10 percent, the data are also considered reasonably compatible. For example, if a single individual reports income of $1,300 (when the Medicaid cutoff is $1,354) but the data source reflects income of $1,400, the difference of $100 is less than 10 percent. These data would be considered reasonably compatible and would result in the individual being determined eligible for Medicaid without the risk of the determination being identified as an error. The flexibility to set state standards can increase the share of eligibility determinations that are determined through data-driven processes at both application and renewal.

Endnotes

1 L. Ku, E. Steinmetz and T. Bysshe, "Continuity in Medicaid Coverage in an Era of Transition," Association for Community Affiliated Plans, November 2015.

2 P. Boozang, L. Braslow, A. Fiori, "Enrollment Churning in Medicaid," Manatt Health Solutions.

3 T. Brooks, S. Miskell, S. Artiga, E. Cornachione, and A. Gates, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Practices as of January 2016: Finds from a 50-State Survey," Kaiser Family Foundation, January 2016.

4 Alabama, Colorado, Idaho, Louisiana, Massachusetts, Maryland, Ohio and Rhode Island.

5 "Coverage Expansion Learning Collaborative: Medicaid/CHIP Renewals: State Practices, Lessons Learned and Opportunities," CMS Medicaid and CHIP Learning Collaborative, August 2015. Accessed online on February 2, 2016 at https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/coveragelc-medicaid-chip-renewals.pdf.

6 *Ibid.*

7 Express lane eligibility is a policy option that was enacted for children in Medicaid and CHIP through the CHIP Reauthorization Act of 2009. States must receive waiver approval from CMS to use express lane eligibility for pregnant women, parents and other adults. For more information, see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/express-lane-eligibility.html.

8 In August 2015, CMS released guidance making a temporary enrollment and renewal strategy that was offered in May 2013 a permanent state plan option. This strategy provides states with the opportunity to use data from the Supplemental Nutrition Assistance Program (SNAP) to support income eligibility determinations at both initial application and renewal for certain groups. For more information, see https://www.medicaid.gov/federal-policy-guidance/downloads/sho-15-001.pdf.

9 *Op. cit. (3).*

10 S. Karp, "Enrollment Modernization: Changing the Culture, Organization and Structure of Health Program Enrollment," keynote address at Building Blocks for Universal Health Care in New York: Bridging Coverage Gaps with Information Technology Conference, May 2008.

11 80 *Fed. Reg.* 75817-75843 (December 4, 2015). Available at https://www.federalregister.gov/articles/2015/12/04/2015-30591/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010.

12 *Op. cit. (3).*

13 42 CFR 435.948.

14 T. Brooks and J. Kendall, "Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and Exchanges," Robert Wood Johnson Foundation, July 2012.

15 R. Kennedy, "Medicaid & CHIP Eligibility Culture Change in Louisiana," Presentation at Maximizing Enrollment Collaborative meeting in New Orleans, LA, March 2010. Accessed online on February 6 at http://www.nashp.org/sites/default/files/culture.change.louisiana.pdf.

16 *Op. cit. (3).*

17 Department of Health and Human Services LEP Policy Guidance for HHS Recipients - August 8, 2003.

18 *Op. cit. (15).*

19 42 CFR 435.916(a)(3)(iii).

20 J. Ryan and S. Artiga, "Renewals in Medicaid and CHIP: Implementation of Streamlined ACA Policies and the Potential Role of Managed Care Plans," Kaiser Family Foundation, June 2015.

21 *Op. cit. (1).*

22 42 CFR 435.916(a).

23 *Op. cit. (3).*

24 For more information on ACA renewal requirements, see T. Brooks and M. Heberlein, "Renewing Medicaid Under the Affordable Care Act," Georgetown University Center for Children and Families, April 2014.

25 Social Security Act 1137. [42 U.S.C. 1320b-7]

26 If an individual attests to citizenship or eligible immigration status that cannot be verified through electronic data matches, the individual must be given a 'reasonable opportunity' period to provide documentation. During this period, states must provide Medicaid to the individual based on the attestation.

27 42 CFR 435.952(c)(1).

28 Op. cit. (3).

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20007
Telephone (202) 687-0880
ccf.georgetown.edu