Harnessing Technology to Streamline Enrollment: Experience from Eight Maximizing Enrollment Grantee States

A Maximizing Enrollment Report

By

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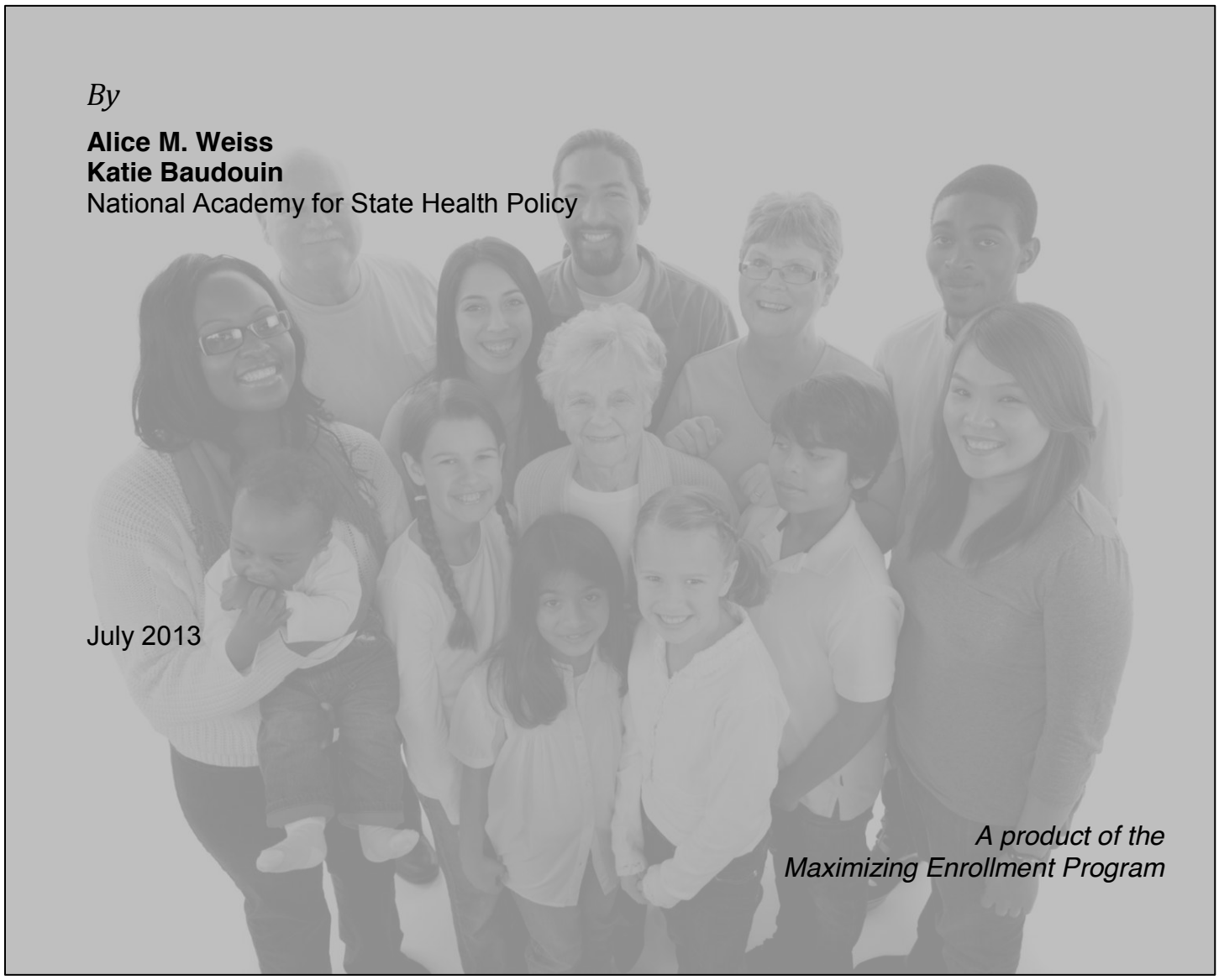

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Robert Wood Johnson Foundation

Maximizing Enrollment is a national program of the Robert Wood Johnson Foundation with technical assistance and direction provided by the National Academy for State Health Policy.

About Maximizing Enrollment

The *Maximizing Enrollment* program has worked intensively with eight states to help them more effectively use data to improve performance in enrolling and retaining eligible individuals. This report presents key lessons learned from grantee states' work on strategies to make enrollment more simple, efficient, and accessible. Strategies were adopted in four areas: application and renewal simplifications, customer interfaces, system functioning, and workflow management. These strategies go beyond what federal law requires, and will be useful as states move forward with ACA implementation.

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July 2013

Dear Reader,

In 2009, eight states—Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin—received million-dollar grants from the Robert Wood Johnson Foundation's Maximizing Enrollment program to improve enrollment and retention of children in Medicaid and the Children's Health Insurance Program, and to promote best practices in enrollment simplification that could offer new models for the nation. With the enactment of the Affordable Care Act in 2010, the Foundation expanded the goal of the program to encompass state eligibility and enrollment strategies to prepare for newly eligible individuals in 2014.

The grantee states participated in a diagnostic assessment to identify areas of strength, challenges and opportunities; created improvement plans; received technical assistance; and participated in a peer-learning network. Four years later, Maximizing Enrollment grantee states have implemented new strategies and pioneered innovations to streamline and simplify eligibility, enrollment and retention. They used grant funds to revamp cumbersome, paper-driven enrollment processes, modernize systems, change business processes, and procure new tools.

In this series of final reports, the National Academy for State Health Policy—the national program office for Maximizing Enrollment—will explore the results of grantee states' efforts to:

- Harness technology to make enrollment more simple, efficient, and accessible;
- Simplify and streamline processes to reduce unnecessary paperwork and relieve burden on both applicants and eligibility workers; and
- Manage programmatic change by setting a consistent, data-driven vision for coverage among the state agencies and local entities that share responsibility for health and human services programs.

Please visit www.maxenroll.org to download the reports in this series. Throughout 2013, we will also hold virtual and in-person meetings where you can learn more about our states' work to transform their enrollment systems and policies. We hope you will join us.

Sincerely,

Catherine Hess
Co-Director
Maximizing Enrollment

Alice Weiss
Co-Director
Maximizing Enrollment

Our sincere thanks to the Robert Wood Johnson Foundation for its support, to our partners and technical assistance faculty, and especially to the state teams who participated in the Maximizing Enrollment program.

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Executive Summary

Since 2009, the eight states (Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin) participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program have worked to streamline eligibility and enrollment systems for children and those eligible for coverage in 2014. Although the participating states began their work before the enactment of the Patient Protection and Affordable Care Act (ACA), several of their technology-based solutions have paved the way for new simplifications that the ACA requires of all states. Maximizing Enrollment states are more likely than other states to have adopted technology-based simplifications and have piloted inventive strategies that go beyond what federal law requires that are worthy of consideration as states move forward with ACA implementation.

This paper shares findings and lessons learned from Maximizing Enrollment state grantees' experiences using technology to streamline enrollment. Strategies were adopted in four areas: 1) application and renewal simplifications; 2) customer interfaces; 3) system functioning; and 4) workflow management.

All grantee states used technology to simplify the application and renewal process to increase worker efficiency and to manage an increasing caseload with diminishing resources. Six out of eight Maximizing Enrollment states allow consumers to fill out and submit electronic applications for Medicaid or CHIP health coverage online.[1] Five (Alabama, Louisiana, Utah, Virginia, and Wisconsin) implemented online renewal of benefits for Medicaid and/or CHIP,[2] and five (Alabama, Illinois, Louisiana, Virginia and Wisconsin) have implemented telephonic applications and renewals for Medicaid and/or CHIP program. Maximizing Enrollment grantees' other innovative application and renewal strategies include:

- *Online Submissions of Verifications* in order to reduce rates of incomplete applications.[3]
- *Automatic Data Population into Eligibility System* to reduce data-entry time for eligibility workers and reduce errors that could lead to administrative denials or delays for the state.
- *Bar Coding* application materials to more easily match documents to the electronic case record.
- *Translation and Toggling From English to Foreign Language Versions* of online applications.
- *Horizontal Integration with Human Services Programs* through online applications that allow beneficiaries to apply for multiple health and human service programs.
- *Telephonic Signatures* that allow workers to create a brief recording of the application transaction.
- *Automated Voice Response* systems that allow families to renew by phone, helping to save money (postage, paper and staff time) and improve families' access to renewals.

States preparing to implement new technologies will want to consider operational issues, including consumer preference in usage, reducing redundancies among assistive technologies, using data to monitor and improve performance, and ensuring new technologies are accessible to limited English proficient, disabled and other populations with special needs.

Technological enhancements improved states' ability to communicate with consumers about their application, renewal, or case status. Common strategies employed by grantees included expanding application access, providing updated information in a timely manner, answering questions in a consumer-friendly way, and allowing applicants and enrollees to more easily check their benefit status and update their personal information. Key strategies included:

- *Online Accounts* to foster two-way communication between the Medicaid or CHIP agency and the client, allow clients to keep their accounts updated, and reduce call center volume. Utah's myCase system is a model for third party access and electronic notices that may be interesting to other states.
- *Self-Service Kiosks* to expand access to and provide assistance with the online application, particularly in rural areas where in-person assistance is unavailable or Internet connectivity is unreliable. Special planning may be required to make kiosks accessible to individuals with low literacy, limited English proficiency, or physical disabilities.
- *Online Chat* between applicants and eligibility staff through instant messages while completing an online application. Online chat allows staff to serve multiple applicants at once. Utah's online chat usage increased quickly after implementation, from 6.3 percent of in-bound contacts in 2010 to 14.4 percent in 2012.

Maximizing Enrollment grantee states used technology to improve eligibility system operations, streamline eligibility verification and determination processes. Grantee states developed and implemented strategies to rely less on paper-based verifications and case files. Increasing electronic access to case information will help states respond to the increase in application volume with ACA implementation in 2014. Influential system changes adopted by grantees included:

- *Electronic Verification* will be required of all states in 2014, with states expected to rely primarily on federal and state electronic data sources for eligibility documentation. Utah's eFind system takes electronic verification a step further by collecting all verification information into one location. The $2 million system saved the state $2.1 million in its first year of operation and is projected to save the same or more in subsequent years.[4]
- *Electronic Document Management* (EDM) systems that accept and manage all eligibility documentation electronically. EDM allows states to collect and process verification documents centrally, speed up collection, and better manage how work is assigned. Alabama's CHIP Document Imaging and Workflow Management System has reduced the average processing time for all CHIP applications from six days to just one day.[5]
- *Electronic Case Records* (ECR) to track and record all case-related information and transactions in an electronic file that is secure, storable and shareable among workers. ECR implementation eliminates paper case files, fosters better accuracy and timeliness, and allows more flexible workloads, remote workforces, improved oversight, and better customer service.
- *Express Lane Eligibility* (ELE) allows states to use income determinations from programs like SNAP to facilitate Medicaid or CHIP enrollment.[6] ELE has been implemented by four Maximizing Enrollment states for children, and Alabama and Massachusetts are pioneering adult ELE programs that may reduce their enrollment burden in 2014.

States revamping their eligibility systems and processes changed how they managed their workflow, including redesigning business processes, restructuring jobs, and introducing new management tools and incentives. States needed to allow themselves the freedom to invent new, different and more modern ways of doing business rather than simply incorporating old, outdated, and unnecessary processes into an electronic environment. Change strategies included:

- *Business Process Redesign* to adapt to the shift from a paper-based to an electronic environment. Utah developed a "throughput operating strategy" that focused on "feeding the control point" – the eligibility worker – to maximize the worker's capacity to move cases to

complete decisions. Using these new tools, Utah was able to eliminate the backlog of cases, manage an increasing workload of cases with fewer staff, and bring the timeframes for outstanding tasks from 108 days to 10-15 days.

- *Rethinking Workforce Structures and Roles* in light of new technologies. New York began moving from a county-based to a centralized enrollment system by centralizing renewal case processing and offering a telephone renewal option, which is now available in 31 counties. Utah transitioned from a region-based to a state-based operational approach and restructured worker roles to better fit the technologically-enabled eligibility system. As a result, Utah has been able to manage an increasing caseload with fewer workers, error rates have dropped, and processing costs have dropped from $45 to $35 per case.[7] Louisiana adopted a local empowerment model that, along with a shift to task-based work, helped Louisiana reduce denials of children eligible for coverage at renewal, from 22 percent in 2001 to less than 1 percent in 2011.
- *Management Tools and Incentives* to manage workers in a paper-free environment. Louisiana transitioned 42 percent of its Medicaid eligibility workforce to remote status, saving money in office costs and improving worker productivity and retention. Utah is piloting a "pay for performance" initiative that has grown from 45 to 400 workers due to increased demand for voluntary participation among workers. Workers participating report improved morale and appreciation for the bonuses.[8]

Lessons for Other States: Maximizing Enrollment grantee states have learned important lessons from their experiences on the leading edge of technological improvements, including:

- **Let Policy Drive the Technology.** Participating states reported their greatest successes when technology became a lever to accomplish a larger goal, rather than an end in itself.
- **Technology Does Not Eliminate the Need for "Human Touch."** Grantees that worked to simplify and automate the enrollment process learned that in many cases there is no replacement for the value of direct human contact.
- **Training In-House IT Staff Can Pay Significant Dividends.** While many states rely on technology support from vendors, a few of the Maximizing Enrollment states were able to reap significant rewards when they trained their own IT and policy staff on the new technologies being implemented.
- **New Technologies Require New Approaches and Processes**. Many grantee states reported that technology changed their business operations substantially.
- **Involve Local Staff in the Change Process.** Grantee states can attest to the value of involving local staff in planning and implementing change.
- **Plan for Security Protections.** Two of the grantee states experienced security breaches during the program. While both states thought their security was adequate before the breach, both regretted not having clearer protocols for sensitive information or a plan for post-breach management.
- **Leadership and Vision Are Essential.** Grantees clearly benefited from the strong leadership and vision articulated by leaders to support using new technology. As one official in Utah observed, "nothing implements itself."
- **Change Takes Time**. While new technologies may be implemented on a speedy timeframe, grantee state experience demonstrates that real change in terms of worker culture and agency impact happens more slowly.

Future Directions: States may want to consider additional strategies for the future, including: embracing new technologies, including data profiling to support outreach efforts; making mobile applications accessible, translating application materials, and preparing for new application technologies; creating streamlined plan selection capacities and improving interfaces among state systems; and ensuring truly seamless transfers. Federal officials and states will need to work together in collaboration to promote continuous improvement of system in achieving the goal of maximizing enrollment of those eligible for coverage.

The following report shares the successes and challenges grantee states experienced with adoption of technology in each of these four areas. States considering technological improvements will benefit from the lessons Maximizing Enrollment states learned throughout the process.

[1] All of the six states that provide consumer-facing online applications except one (Illinois) accept electronic signatures. Two more states (Massachusetts and New York) allow electronic submission of applications through application assisters.

[2] Three of the five states that have implemented online renewal (Alabama, Utah and Virginia) implemented or improved access during the grant period. An additional grantee state (New York) developed an online renewal tool during the grant period. This tool is used by their centralized Enrollment Center to process renewals in 31 counties.

[3] Rebecca Mendoza, "Getting in the Act? The State of State Implementation of Health Care Reform: Virginia's Experiences Using Technology to Streamline Enrollment", slide 16.

[4] State of Utah, eFind one-page information sheet. Uploaded to StateRefor(u)m, June 21, 2012. http://www.statereforum.org.

[5] Alabama Department of Public Health, data received from state Maximizing Enrollment team, Bureau of Children's Health Insurance, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees, April 5, 2013.

[6] Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, *State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future*, (Washington, DC: State Health Reform Assistance Network, 2012).

[7] For more information on Utah's approach to Workforce Culture Change, see Nicole Dunifon, *IT Innovations One Piece of the Puzzle: A Look at Utah's Workforce Culture Change*, (Washington, DC: Maximizing Enrollment, Forthcoming.

[8] Id.

Introduction

"One of the most important decisions we made early on was that we were going to let the policy drive the technology, not the other way around."

– Diane Batts, Louisiana Medicaid Deputy Director

In 2009, eight states received grants from the Robert Wood Johnson Foundation as part of the Maximizing Enrollment program to increase enrollment and retention of eligible children into Medicaid and the Children's Health Insurance Program (CHIP) and to establish and promote best practices in streamlining eligibility and enrollment systems, policies and procedures to share with other states. With the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, the Foundation expanded the goal of the program to encompass state strategies to modernize eligibility, enrollment, and retention policies to prepare for newly eligible individuals in 2014. After four years of work in the program, these Maximizing Enrollment program states have made important strides forward in their efforts to streamline and simplify eligibility and enrollment, with many states pioneering new approaches in their use of technology to promote simpler, more efficient, and more accessible enrollment. In this paper, the term "technology" means the use of alternative media (electronic, Internet supported, and other devices making use of new technological tools) to support simplified eligibility and enrollment procedures.

The states participating in Maximizing Enrollment initiated their work before the enactment of the ACA and many of their strategies have paved the way for the ACA's approach to using technology to simplify the enrollment process. Although many of the Maximizing Enrollment states' strategies are now required under the ACA, Maximizing Enrollment states are also piloting inventive strategies that go beyond what federal law requires and are worthy of consideration as states move forward with ACA implementation.

A guiding mantra for many Maximizing Enrollment states was one aptly expressed by Louisiana's Deputy Medicaid Director Diane Batts as "let the policy drive the technology." Many of the Maximizing Enrollment states saw their greatest successes in technological advancements when they let their policy needs drive and inspire their technology solutions. In this way, technology improvements are often not a goal in their own right, but technology has been instead viewed as a means to achieve another valued end. With the enactment of the ACA and the magnitude of change required in how eligibility and enrollment systems function, the Centers for Medicare and Medicaid Services (CMS) indicated that "[s]ystem transformations will be needed in most [s]tates to accomplish these changes."[1] Given states' new imperative for system redesign with policy changes as a driver, the strategies and lessons learned by Maximizing Enrollment states may offer useful insights to other states as they work to transform their eligibility and enrollment systems for 2014 and beyond.

Technology-enabled strategies observed among the Maximizing Enrollment grantee states are grouped into four main areas: 1) application and renewal simplifications; 2) customer interfaces; 3) system functioning; and 4) workflow management. This paper will discuss advancements and innovations in technology from the experience of the Maximizing Enrollment grantee states – Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin – in each of these four areas of state eligibility and enrollment simplification work. In the Appendix, there is a chart that maps each state's adoption of the strategies discussed. This paper includes all of the technology strategies that these states have adopted, including those adopted outside of the Maximizing Enrollment work, to demonstrate these states' approach to technology and their accomplishments, as part of Maximizing Enrollment and outside the program.

Background

In 2009, the Maximizing Enrollment grantee states participated in a "Diagnostic Assessment" to help each understand its strengths, challenges and opportunities in its effort to simplify enrollment for children. This diagnostic assessment gathered data from the grantee states on their eligibility and enrollment policies and procedures including the creation of a process map for enrollment and renewal and key informant interviews during a site visit. Each state received an individual assessment and these findings were summarized in a final report. The value of states adopting technologies to support streamlined enrollment was a key theme that emerged from the assessment.

The diagnostic assessment revealed that most Maximizing Enrollment states were facing major barriers to implementing system modernizations, including the age and poor condition of existing legacy eligibility systems, the absence of funding for IT system improvements, eligibility system resources that were managed by separate agencies that often did not share the same priorities as the Medicaid or CHIP program, and the lack of skilled IT staff or vendor contracts to support implementation.[2] The report recommended states "invest in system improvements identified as having a high productivity payoff."[3] The report also identified technology as an essential component in improving states' capacity to identify problems, monitor performance and collect eligibility and enrollment data. Finally, the report cautioned states that technological advancements, while promising, could never replace the need for "human touch" in the enrollment process, especially given the low literacy rates, language needs and complex lives of many applicant populations.

Several Maximizing Enrollment states had made important progress prior to the grant program. Two states, Louisiana and Wisconsin, had already implemented a number of strategies, including using electronic case records to manage their programs and online applications. Wisconsin was also using an online screening tool to help applicants decide if they should apply for health and other human service programs and customer-facing electronic accounts. Utah's Department of Workforce Services was just launching what would become a statewide initiative to modernize all human services eligibility determination processes, including the overhaul of the state's eligibility infrastructure that would allow electronic links to other programs and systems to verify eligibility. While all but one state were providing online applications and five out of eight states were providing online renewals, many of the states still required applicants to print out, sign, and mail in the final page of an application, and most states had only applied these simplifications to their child populations.[4]

The ACA requires states to develop and implement new coordinated, consumer-friendly and technology-enabled strategies for enrolling individuals into public and publicly subsidized health coverage.[5] State enrollment and information technology systems for Medicaid that were outdated and paper-based are to be reinvented as an "enrollment superhighway" that will provide a streamlined, integrated enrollment process for all health coverage programs, including Medicaid, CHIP, Basic Health Programs and premium tax credits and cost-sharing reductions provided for qualified health plans purchased through a health insurance exchange.[6] System redesigns that fulfill the ACA's eligibility and enrollment policy imperatives are a critical component to ensure successful enrollment of eligible individuals and, ultimately, access to care. Recognizing states' need for additional resources to modernize their eligibility systems to comply with these new requirements, CMS provided guidance allowing states to apply for enhanced federal funding to support the development, implementation and maintenance of new IT systems.[7]

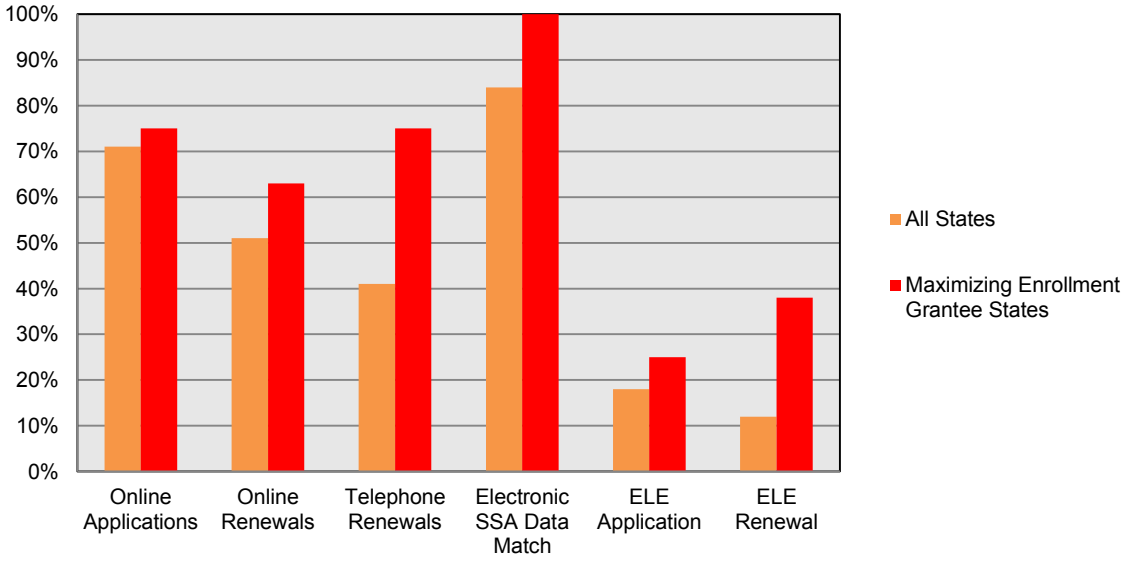
Key ACA provisions that all states must have in place by 2014 to promote simplified enrollment that rely on technological improvements include:

- Developing an Internet website portal for applications, benefit and other program information;
- Allowing submission of applications and renewals online and by phone;

- Using electronic verifications to document eligibility to the greatest extent possible, including real time data exchange with federal and state data sources (if the state determines that the information in those sources is available and "useful");
- Providing an electronic notice option to consumers that allows applicants and enrollees to elect to receive coverage status or other program information electronically through a secure individual account; Securely exchanging electronic data with health insurance exchanges and other insurance affordability programs, as needed to determine eligibility;
- Providing the capacity to request appeals online or by phone; and
- Upgrading eligibility system functionality to comply with these new requirements and the Secretary's standards for electronic enrollment.[8]

State adoption of technologies supporting simplified enrollment also accelerated significantly during the four years of the Maximizing Enrollment program, most likely in part due to the federal policy changes under the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the ACA. As the chart in Figure 1 below demonstrates, state adoption of a number of technology-enabled simplifications has increased dramatically for state Medicaid programs in just the past three years. As a result of the availability of new enhanced federal matching funds, nearly all states (92 percent) are pursuing a major upgrade of their Medicaid eligibility systems, intended to completely modernize how Medicaid eligibility determinations are made.[9] Maximizing Enrollment grantee states are leading the field in adoption of each of these new technologies and have a valuable story to tell about their experience with implementation.

Figure 1. State Medicaid and CHIP Programs with Technology-Enabled Simplification Strategies in 2012



Source: Adapted from Martha Heberlein et al., *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013* (Washington, DC: Kaiser Family Foundation, 2013)

While it is clear that the work of the Maximizing Enrollment states on streamlining enrollment was part of a broader movement among states to adopt technology-enabled solutions, the grantees' work warrants examination, both as an example of the broader trend and because of the signal innovations the grantees adopted during this period. Maximizing Enrollment grantees have pioneered new strategies, in many cases paving the way for other states, for new federal policies under the ACA, and for the future.

Key Areas of State Work

Application and Renewal Technologies

All of the Maximizing Enrollment grantee states have leveraged technology to simplify the application and renewal process, although in different ways. A primary goal among all states has been to increase worker efficiency and capacity to manage an increasing caseload with diminishing resources. Providing an electronic application and renewal process that allows applicants or beneficiaries to enter their own personal information saves state workers time and can also lead to fewer omissions, transcription errors, and fewer incomplete applications submitted.[10] Online and telephonic processes eliminate the need for individuals to be physically present at local eligibility offices, making applications and renewals more accessible to those eligible for coverage.[11] Online applications and renewals can also lead to faster processing of eligibility decisions, especially in states using an automated rules engine (logic-based system that can automate eligibility decision-making) that can provide a near-immediate review of the eligibility case record.

Given that all states must implement online and telephonic applications and renewals by 2014 under the ACA, there is much that states can learn from Maximizing Enrollment grantees' implementation experience, both in terms of operational implications and new strategies to consider.

Online Application and Renewal: Six out of eight Maximizing Enrollment states allow consumers to fill out and submit electronic applications for Medicaid or CHIP health coverage online.[12] While most Maximizing Enrollment states had online applications operational before the program launched in 2009, many made improvements to their online applications during the grant period, either as part of or outside the Maximizing Enrollment grant work. Only five of the eight Maximizing Enrollment grantees (Alabama, Louisiana, Utah, Virginia, and Wisconsin) implemented online renewal of benefits for Medicaid and/or CHIP.[13] Three of the five states either implemented or improved online renewal during the grant period. The chart in the Appendix provides more detail on state activity in these and other areas.

Virginia's Online Renewal Process

Virginia's online renewal process for CHIP is already compliant with the ACA standards requiring maximum use of existing data and ensuring that beneficiaries don't need to sign a form to renew benefits.

The Online Renewal Process

- Virginia sends out a mailing 85 days before the renewal date providing a CHIP identification number and PIN code that will enable access to a pre-populated renewal form.
- The enrollee is then able to make updates on the screen or verify that all information is correct and must attest to income or provide updated information.
- Pay stubs can be uploaded online if needed to verify income.
- No signature is required to renew if there are no new applicants on the case.
- The renewal can be electronically submitted and processed.

Maximizing Enrollment grantees have implemented a number of inventive strategies that go beyond what the ACA will require of states in 2014 and may be worth additional consideration by states. These strategies include:

- *Online Submissions of Verifications*: Virginia (CHIP) and Wisconsin allow consumers to submit verification documents electronically. Virginia's CHIP program has reported that allowing applicants and beneficiaries to submit verifications electronically has contributed to increased complete application submissions and a lower denial rate for children due to incomplete applications.[14]

- *Automatic Data Population into Eligibility System*: During the Maximizing Enrollment grant period, Louisiana, Utah and Virginia (CHIP) updated their eligibility system functionalities so that eligibility data entered into the online application would automatically populate an electronic case record in the state's eligibility system. This small but important and technologically complex improvement meant a significant time savings for eligibility workers, who no longer have to enter in new data by hand, and for the state in reducing typographic errors that could lead to administrative denials or delays.

- *Bar Coding:* Utah and Virginia's CHIP program use bar codes on application materials to help the state more easily match application documents to the electronic case record. This is especially valuable in cases where documentation is outstanding and submitted later and can speed the process of ensuring that submitted verifications are married with the pending application in a way the system can recognize and enable additional decisions on the case to be triggered through an automated system.

- *Translation and Toggling From English to Foreign Language Versions:* States are required to ensure that application and enrollment materials are accessible to limited English proficient populations under the ACA. While final standards for state translation of application materials are still forthcoming, CMS has reported they plan to provide a Spanish language version of the application and will provide an outreach and enrollment guide in at least seven languages that will provide written translation of application questions from the online model application, which can be a resource for states using the model application.[15] States that wish to use an alternate application format or that wish to have a foreign-language version may want to consider options for translating their application. A number of Maximizing Enrollment states have invested resources into translating their applications into foreign languages. Alabama built the system functionality to allow online applicants to toggle back and forth between English and a foreign language, enabling the user to translate some of the application as needed to confirm understanding of terms, but implementation has been delayed due to imminent changes to the online application under the ACA's streamlined model application requirements.

- *Horizontal Integration with Human Services Programs:* The U.S. Departments of Health and Human Services (HHS) and Agriculture have issued tri-agency guidance that supports state efforts to integrate benefits and recent ACA guidance gives states the option of using an alternative integrated application to allow low-income applicants to apply for multiple health and human service programs so long as they also provide access to a health-only application upon request.[16] Illinois, Utah, and Wisconsin have online applications that allow beneficiaries to apply for multiple health and human service programs and Wisconsin allows individuals to use an electronic screening tool to determine whether they might be eligible for multiple health and human service programs.

Telephonic Application and Renewal: An increasing number of states across the country now allow applicants to either apply for or renew benefits over the telephone, through conversation with a call center worker or through automated-voice response technology. Five out of eight Maximizing Enrollment states (Alabama, Illinois, Louisiana, Virginia and Wisconsin) have implemented some form of telephonic applications and renewals for Medicaid and/or CHIP programs.[17] Completing applications and renewals over the phone allows workers to ask questions and get immediate answers and complete the process, which can lessen the rate of denials due to incomplete applications or renewals. Some states utilize this option only for renewals, as a signature is not required. For consumers in states that have adopted telephonic signatures, telephonic applications can speed enrollment because the date that the application is "signed" over the phone is considered the application date.

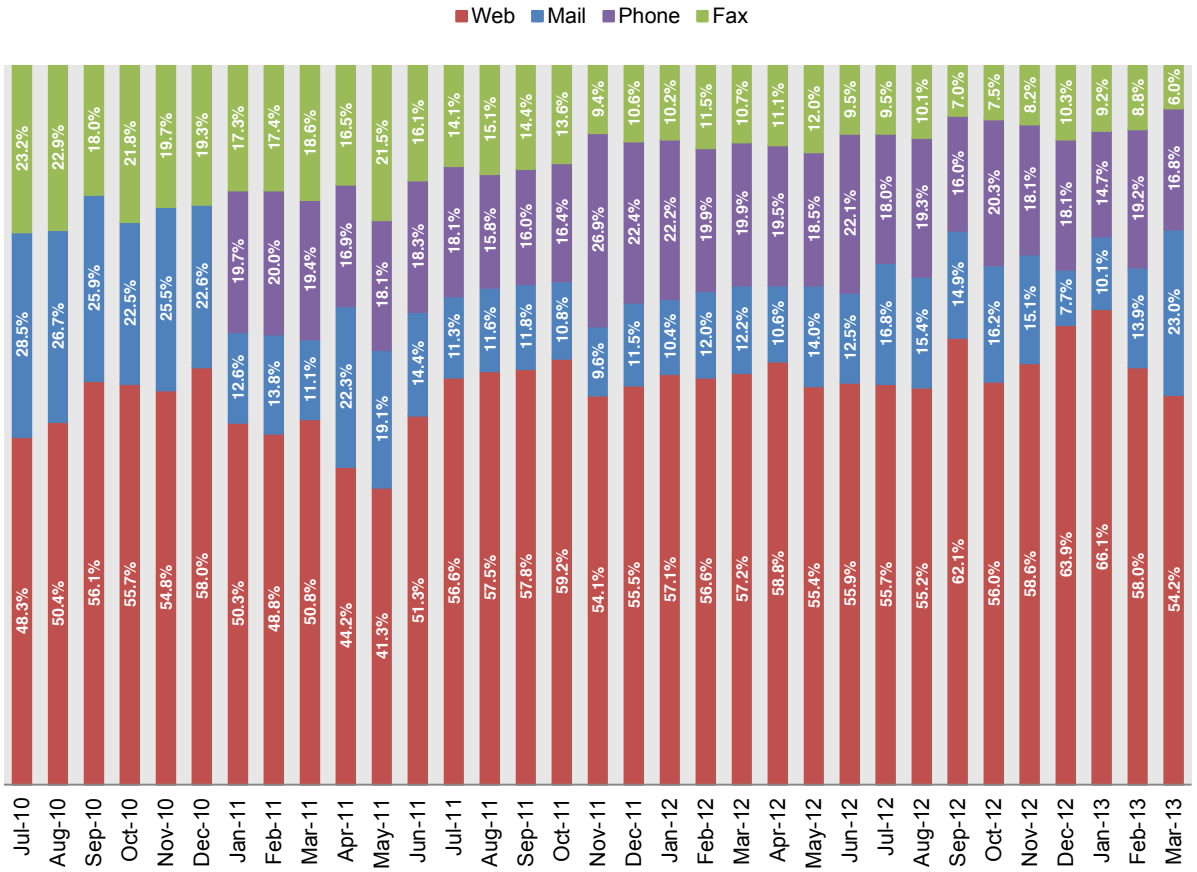
As early adopters of telephonic application and renewal technologies, Maximizing Enrollment states have piloted strategies that other states may want to consider, including:

- *Telephonic Signature:* CMS has indicated that states should be able to accept a telephonic signature to document attestation by the applicant. Virginia's CHIP Central Processing Unit and Wisconsin have adopted systems for telephonic signatures that allow workers to create a brief recording of the application transaction. First, the worker repeats key information shared by the applicant, including a confirmation of household status. Then, the worker reads the applicant her rights and responsibilities and lists any documents needed to complete the application. Finally, the applicant attests to the information. The recording then becomes an electronic file that is attached to the case record for documentation. Wisconsin's experience has been that the entire telephonic signature process takes about five minutes. By contrast, Alabama's CHIP program, ALL Kids, creates a system-generated form summarizing the renewal information received over the phone that is mailed to the enrollee for review and signature. Moving to a telephonic signature from a mail-in process can reduce the time to complete an application, and eliminate the risk that the form may not be returned.[18]

- *Automated Voice Response:* Louisiana adopted automated voice response for Medicaid and CHIP renewals in July of 2004. This phone renewal option allows families to renew whenever they communicate with the state, providing them with a "rolling" or "off cycle" renewal that updates their enrollment for a year following the most recent renewal contact. Individuals can use this option any time they call the LaCHIP hotline, which serves Medicaid and CHIP and is available any day of the week at any hour of the day. All renewal letters also include this information. Under this process, an applicant has the option to renew by using the automated system, and the renewal information is then electronically routed to her local eligibility office. This type of system promotes efficiency for states and was cited by Louisiana as helping to save money (postage, paper and staff time) and improve accessibility of the program's renewal process for families.

As states prepare to adopt technologies to allow for online and telephonic applications and renewals, there are operational issues Maximizing Enrollment states have experienced that warrant consideration. First, a key issue for states has been the extent to which consumers are ready to embrace and use technology, which has varied among states. For example, Virginia adopted telephonic signatures for applications in January of 2011 and that same month received 20 percent of its new applications by phone (See Figure 2). Virginia's experience with Internet usage also shows that consistently roughly half of applications and a third of renewals are being submitted online. By contrast, Alabama implemented telephonic renewals for CHIP enrollees and has seen very low consumer use of this option, with only 163 enrollees attempting to renew telephonically (139 successfully) since the strategy became available in March 2011.[19] Former Alabama Medicaid and CHIP enrollees interviewed about enrollment preferences in focus groups reported that they preferred online or paper applications over telephone renewal.

Figure 2: New Applications by Received Method July 2010 - March 2013



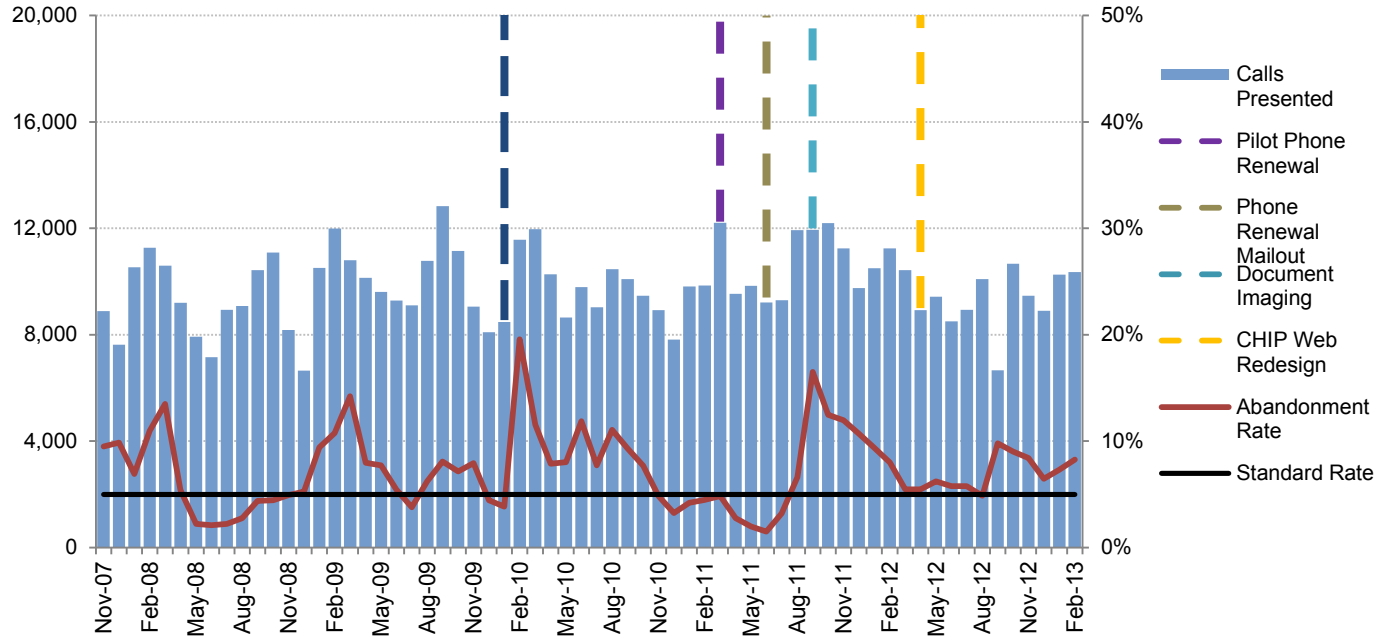
Source: Data received from Virginia's Maximizing Enrollment Team and collected from Virginia's Central Processing Unit. CPU Application and Renewals by Method. Kate Honsberger, email to Maureen Hensley-Quinn, April 17, 2013.

States have also developed new strategies to drive traffic to and deliver assistance for online and telephonic options. Utah has used eChat technology (discussed in greater detail in Consumer Interfaces, below) to answer questions during the application process or about a pending, open, or denied case. Louisiana crafted mailings to remind consumers about renewal and prompt them to use new telephone renewal options. Alabama, Utah, Louisiana have used focus group research to learn from consumers' challenges in the enrollment process and applied what they learned to adjust strategies for enrollment options.

Maximizing Enrollment grantees have also leveraged data to monitor and improve the effectiveness of these technologies in practice. Virginia has tracked the impact of telephonic enrollment on its vendor call center performance, including the increase in duration of the calls and total agent hours used to deliver this service. From this data, Virginia was able to determine that including a telephonic signature increased the average call time for all calls initially from a little more than four minutes to six minutes per call.[20]

Alabama's ALL Kids (CHIP) program collects and tracks monthly call center volume and abandonment rates and overlays key policy changes to measure impact of the change on volume and call wait times/abandonment by consumers. (See Figure 3 below) In order to make the most of online and phone applications, states will want to capture and track data on bottlenecks that impede consumers' use of these technologies.

Figure 3: ALL Kids Monthly Call Volume and Abandonment Rate
November 2007 - February 2013



Source: Alabama Department of Public Health, data received from Maximizing Enrollment team, Bureau of Children's Health Insurance, *Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees*, April 5, 2013.

A final issue that states implementing new online and telephonic application and renewal technologies must keep in sight is being mindful in their implementation that they are not undermining access to traditional paper-based and in-person applications and that their processes are responsive to the diverse needs of the applicant population, including factors like language, disability, behavioral health, and Internet connectivity access. Access to all modalities is not only mandated by the ACA, but will be essential to ensuring access for the significant percentage of the population for whom other application and renewal options are not viable. States' investments in new technologies must support a full spectrum of accessible, functional application and renewal approaches.

Consumer Interfaces

Over the course of the grant, all grantee states made progress in their use of technology to interact more effectively with consumers. Common strategies employed by grantees included expanding application access, providing updated information in a timely manner, answering questions in a consumer-friendly way, and allowing applicants and enrollees more access to their benefit status and making it easier for them to update their personal information. These strategies helped improve staff productivity and consumers' access to information. Early implementation of these strategies means grantee states in some cases are already compliant with some new ACA requirements aimed at increasing consumer access to information. Under the ACA, all states will be required to:

- *Provide application, renewal, appeal and benefit information accessible to consumers electronically, by phone, in person and by mail;*
- *Receive and verify eligibility information electronically;*
- *Create secure electronic portals for submitting applications for coverage and Internet websites;*
- *Create an electronic notices option; and*
- *Provide consumer assistance for Medicaid, CHIP and exchange coverage.*[21]

Online Accounts: Online accounts can foster two-way communication between the Medicaid or CHIP agency and the client, allow Medicaid and CHIP clients to keep up with their accounts at their convenience, and reduce calls to a call center. By the end of the grant period, seven of eight Maximizing Enrollment grantee states (all but New York) provided access to online accounts, which reflects similar adoption of this technology across the country. The robustness of online accounts varies widely across states that have implemented them. Most online accounts allow applicants to complete an application, or to start one and then return to it later, still others also allow users to view the status of their account and report changes to demographic information. The more robust the online account, the more benefit the state will see in terms of reduced contacts and increased administrative savings.

Massachusetts' web portal, called the Virtual Gateway, allows families to apply for multiple programs, including Medicaid and CHIP, through registered community-based assistors called Virtual Gateway providers. My Account Page (MAP) was created to allow registered Virtual Gateway providers to access basic account information and report changes in contact or demographic information for clients. In 2010, with the support of the Maximizing Enrollment project, Massachusetts started allowing direct access to MAP by enrollees who are heads of household. Heads of household can set up a Virtual Gateway account with only their name, date of birth, an email address, and a four-digit PIN of their choosing. Once that account is active, they can use that unique username and password to manage certain aspects of their account using MAP. They can view case status, health insurance information, eligibility notices, and outstanding items needed for eligibility determination. Through MAP, users can also view the current status of documents submitted to the agency and submit changes to certain basic information.[22] The state has found that online access to account information and encourages retention by reducing procedural closures.

Utah's myCase, an online account system implemented in November 2010, demonstrates the great potential of online accounts. The functionality of the myCase system goes far beyond most states' online account systems in place in 2013. MyCase's major functionalities include:

- Displaying basic case information
- Allowing customers to report changes online
- Allowing customers to submit applications and renewals online
- Allowing customers to view electronic notices online
- Integration with eREP, Utah's rules-based eligibility system, allowing for greater automation in eligibility determinations and notices [23]

Electronic communication and data sharing come with an element of risk and the stringent security measures put in place by the Health Information Portability and Accountability Act (HIPAA) may not always be enough to protect health, financial, and other sensitive information. Utah experienced a data breach in 2012 and, as a result, an unauthorized third party accessed 780,000 myCase users' data – including 280,000 social security numbers. The state identified the cause as a default password that hadn't been changed in the department responsible for all IT systems, including myCase. In response, the state immediately alerted the media as well as affected individuals that the information had been compromised. They used myCase to share information quickly but also held community meetings, sent out paper notices, and opened a hotline for concerned citizens to call for more information. To protect their users from fraud, the state provided credit monitoring services for those whose social security numbers were involved in the breach. The state learned that you cannot assume things are always working as they should; that interagency agreements should have good deliverables and that all parties should know what is expected of them.

Grantee states have implemented additional strategies worth considering as states contemplate whether to create customer-facing online accounts:

- *Third-Party Access:* Some states have allowed individuals who have the applicant or enrollee's permission, including application assisters, family members, and other designated representatives, to log into a Medicaid or CHIP online account on the applicant or enrollee's behalf. In addition to increased convenience for many, third-party access is essential for those who need assistance applying for and managing their health insurance, particularly those with mental or physical impairments. Massachusetts and Utah have implemented this strategy. In Massachusetts, third party access is limited to Virtual Gateway providers through the My Account Page. In Utah, clients using myCase can designate an authorized representative to access their account information. Clients can manage how much access to their case the representative is allowed and can limit the access to a certain time period. All authorized representatives must agree to terms and conditions to gain access to account information.[24] Third party access can improve retention by allowing someone else to keep up with timelines and documentation requirements, particularly those with mental or physical impairments. Under the ACA, states will be required to accept applications submitted by authorized representatives on behalf of an applicant, so building in third party access capacity may be something all states will want to consider.[25]

- *Electronic Notices:* MyCase gives customers the option to receive notices through the mail, to also have them sent to their account, or to go completely "paperless" and have notices only shared through the online account. Users must sign into their myCase account to actually view the notice, protecting sensitive information from others. Since Utah implemented e-notices in 2011, they have become a standard feature of eligibility in Utah. Under the Utah protocol, consumers can opt into receiving notices electronically and can choose to receive information either through email or text communication that new notices are available for review or that an interview is needed. All notices regarding hearings are sent through the mail. In 2012, 63 percent of households enrolled in Medicaid or CHIP were using myCase and, of these 39 percent had opted for eNotices. Between implementation in 2011 and 2012, Utah sent 101,000 eNotices, 26,000 text eAlerts and 551,000 email eAlerts, representing 40 percent of all notices sent. The state estimates annualized savings from reducing paper notices sent out to be $522,408.[26] Providing electronic access to notices was not in line with CMS's existing regulations in 2010. The state and federal agencies agreed to limit Utah's initial implementation to a pilot and CMS outlined operational parameters.[27] Today, the national requirements for electronic noticing are based on Utah's pilot process.

Kiosks: In an effort to bring online applications to populations with limited Internet access, several states have developed and deployed self-service kiosks. Two grantee states, Louisiana and Alabama, have implemented kiosks to expand access to and, in the case of Alabama, provide assistance with the online application. Kiosks can be effective in rural areas where access to in-person assistance through an eligibility office or community-based application assister is inconvenient, or where Internet connectivity is sparse or unreliable. Kiosks can also extend capacity to receive applications in understaffed local offices. While kiosks can go a long way to remove the barrier of access to hardware or Internet connectivity, additional barriers often remain. States must consider how to address the needs of individuals with low literacy or limited English proficiency or those with physical disabilities when implementing technology that might otherwise be inaccessible to certain populations. In some cases, these considerations are part of the kiosk design process by ensuring physical access or access for limited English proficient or visually impaired applicants and, as in Alabama's case, providing translation assistance to Spanish-speaking users. A person's ability to complete an application successfully using a kiosk ultimately depends on how user-friendly the online application is. Alabama collects data on applicants' experience with the online application and found that 89 percent of applicants did not require assistance.[28]

Louisiana's kiosks consist of dedicated computer terminals in Medicaid eligibility offices available for use by all clients. As part of their Maximizing Enrollment grant, the state has investigated custom kiosks and appropriate partnerships for placement but, to date, has not been able to secure funding for the hardware needed for implementation.

The Alabama Department of Public Health expanded access to the joint Medicaid/CHIP online application through kiosks in 2008. Additionally, many of the kiosks employ a system, called Audio Visual Application Assistor (AVAA), which provides assistance to individuals with low literacy or limited English proficiency. Kiosks are located in some county health departments and Federally Qualified Health Centers. The kiosks allow applicants to submit verification documents through access to a fax machine and scanner and have a printer for the applicants' convenience. Applications are submitted to the agency through a web service in the same manner as online applications submitted from a personal computer, a function supported by the state's Maximizing Enrollment grant.

While some states have had positive experiences with implementing kiosks at both state and local levels, a comprehensive study of experience with kiosks conducted by Consumers' Union identified

challenges and issues to consider in using kiosks to meet the needs of newly eligible populations under the ACA that may offer useful insights for states considering kiosk implementation. One challenge identified was that some states did not fully integrate kiosks into the state's eligibility systems so that the data provided into a kiosk application had to be manually entered into the state system. Another set of challenges related to barriers to use among the applicant population, including limited computer literacy, low literacy, limited English proficiency, and physical and mental health disabilities. A final issue identified was the need for privacy while entering personal health and income data into a kiosk application, which was incompatible with the open access environment offered by some states. To address these challenges, the report recommended that states design their kiosks stations to automatically populate application data into the state eligibility system, provide a robust consumer assistance model that includes assistance at kiosk stations including through interpreters, and ensure privacy by outfitting kiosks with privacy screens or locating them in private locations.

Online Chat: Medicaid and CHIP agencies are beginning to embrace online chat as they develop and improve their online applications; this consumer assistance technology is already a popular method of customer service in the private sector.[29] Chatting gives applicants an alternate option to ask questions while completing an online application. The technology benefits eligibility staff as well, allowing them to provide assistance to multiple applicants simultaneously. Utah and Louisiana are the only Maximizing Enrollment grantee states using this technology.

Utah implemented eChat in 2010 using the state's existing technology platform. EChat allows consumers to communicate through instant messaging with eChat communications staff regarding the application process or a pending, approved or denied case. The system also allows application assisters to chat with an eligibility specialist while assisting an applicant with their application.[30] EChat usage by consumers has grown over time. In March 2012, eChat communications represented 14.4 percent of in-bound contacts – up from 6.3 percent in August 2010. To hire staff with appropriate skills for the new technology, the Utah Department of Workforce Services (DWS) recruited interested and experienced staff and supervisors from the call center and conducted interviews for eChat applicants online to assess workers' capacity to communicate clearly and succinctly in a text-based environment. Utah piloted eChat before the statewide launch.

Utah learned lessons that might be helpful to other states considering eChat technology. The first is that customers looking for help will seek it out using all means available – even simultaneously. When Utah launched eChat, they allowed consumers to use it for any question relating to their application for benefits. The state immediately noticed that customers on hold with the telephone call center were also awaiting a response via chat. The state realized it needed to make a change, since eChat was effectively increasing their work burden instead of reducing it. Utah also learned that chat is not a one-size-fits-all solution, that some problems require verbal assistance. Utah addressed both issues by routing eligibility questions to the call center and technical questions about the online application to the chat.[31] In this way, Utah is preventing consumers from "double dipping" for assistance and also ensuring that more complex eligibility issues are handled more effectively through interactive verbal communication.

Louisiana began using chat technology in December 2012. The state reports that five to seven staff working on the telephone hotline are also trained to answer questions via online chat, though only three are active on the chat at any given time, depending on demand. Online chat staff were selected based on their ability to type quickly and communicate effectively through text. Staff can address only one chat at a time and also answer phone calls. Any member of the public can ask a question using chat, which is accessible from any page of the online application or from the public Medicaid website. The chat function serves a general customer service purpose, with inquiries typically ranging from questions about applications, to case status, to complicated inquiries about the Medicaid program itself. The wait times for this program, albeit a new one, are significantly shorter than wait times for the hotline – wait times on chat are roughly four minutes, compared to an average of 20 minutes for the hotline.

System Improvements

Maximizing Enrollment grantee states employed technology to improve eligibility system operations and streamline eligibility verification and determination processes. A common driver among states spurring system improvements was the need to lessen burdens on eligibility staff in processing applications. Throughout the grant period, grantee states developed and implemented strategies to rely less on paper-based verifications and case files. Reducing or eliminating time spent completing verifications and increasing electronic access to case information will help states respond to the increase in applications they will receive with implementation of the ACA in 2014.

Electronic Verification: All eight Maximizing Enrollment grantee states use an electronic interface to verify at least one eligibility criterion: citizenship and identity. Additional electronic verifications are listed below.

State	Citizenship/ identity (SSA)	Income	Third Party Liability	Other Government income or benefits
Alabama	✓			
Illinois	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓
Massachusetts	✓	✓		✓
New York	✓			
Utah	✓	✓	✓	✓
Virginia	✓	✓		
Wisconsin	✓	✓	✓	✓

Electronic verification is a key component of the ACA's "real time" approach to the enrollment process. Beginning in 2014 states will be required to rely primarily on electronic verification for eligibility decisions with paper available as a backup or secondary source, through the Federal Data Services Hub and state data sources, where available. While some states use electronic data sources to confirm information submitted on an application, others have begun automatically importing available information into the eligibility system, and not asking the applicant for the information at all.

Utah's eFind system takes electronic verification a step further by collecting all verification information into one location. The system is searchable and allows workers to note which data point they've used while processing a case. The $2 million system paid for itself in its first year of operation, saving the state $2.1 million in the first year and projected to save the same or more in subsequent years.[32] Louisiana is in the development phase of a similar system, called the Consolidated Verification Summary (CVS), which is being supported by Maximizing Enrollment grant funds and is modeled after Utah's eFind system

Electronic Document Management (EDM): States with EDM accept and manage all eligibility documentation electronically. In most states, this also entails using a centralized system that stores and allows access to documents for any workers in the system. These documents may be submitted in person or by mail, scanned into the system using a kiosk or home computer, or inputted from another source. In some states, applicants may submit documentation by using the camera function on their smartphone. In many cases, EDM allows states to collect and process verification documents centrally and make them accessible to all workers, enabling the state to improve the speed of receiving documents, the capacity of staff to use documents to work a case, and ultimately to manage how work is assigned based on need. Six of the eight grantee states have adopted EDM (Alabama, Louisiana, Massachusetts, Utah, Virginia, and Wisconsin), with two of these states (Alabama and Massachusetts) implementing EDM with Maximizing Enrollment support.

Massachusetts has found great success in implementing EDM. Begun through pilots in selected enrollment centers in 2009, the state rolled out full implementation of EDM in all enrollment centers in 2011. The state quickly felt the impact of the technology on retention and customer service. With immediate access to documents, eligibility staff are able to answer customers' questions immediately, often resolving outstanding issues for applications that are awaiting final determination. This first-time resolution of issues, along with implementation of other operational efficiencies, has both reduced the volume of calls to the call center and call wait times.

Alabama's CHIP agency implemented a Document Imaging and Workflow Management System, which scans all incoming applications and documents into a centralized system managed in an electronic workflow, in September 2011. In addition to making applications and accompanying documents centrally available, this system has greatly increased the agency's ability to monitor the quantity and type of incoming applications, track the process of an application through the system, and assign work. State data documenting the impact of this system demonstrates it has greatly improved efficiency of the eligibility determination process, reducing the average processing time for all CHIP applications from six days to just one day.[33]

This movement away from paper-based documents reduces the need for physical space for document storage and increases access to eligibility documentation beyond the caseworker processing the case. Implementation of this technology is not without challenges. States will need hardware, including digital scanners or multi-function printers, and the staff to complete the work of digitizing existing documents, which has required dedicated funds that have been hard for states to find given budget pressures in recent years. The availability of more generous federal matching funds to support upgrading eligibility systems and 75 percent enhanced federal Medicaid match for systems-related eligibility work may address some of these issues for states that implement changes before 2015. In addition, the availability of emerging technologies that allow applicants to upload photographs of scanned documents may also create another, lower cost means for applicants and states to share and store electronic documentation.

Electronic Case Records (ECR): ECR enables states to eliminate paper case records completely and instead track and record all case-related information and transactions in an electronic file that is secure, storable and shareable among eligibility workers. Essentially a virtual filing cabinet, ECR systems store images of application forms and verification documentation, notices and requests for information sent to clients, metadata on the members of the case, and records of calls or other activity related to the case. Half of the grantee states (Louisiana, Utah, Virginia CHIP, and Wisconsin) implemented this technology, all either before or outside of Maximizing Enrollment.

An early adopter of ECR, Louisiana has used ECR since 2004. Paper documents submitted to the Medicaid agency, either by mail or in person, are scanned into the ECR within 24 hours and then shredded. The information is accessible across the state and searchable by social security number or name. Universal access to the ECR allows greater flexibility with case processing. A case can be begun by one eligibility worker and finished by another in a different part of the state. This is particularly helpful in the aftermath of hurricanes when it is not uncommon to have an entire eligibility office closed for an extended period of time. The ECR is also accessible remotely, which has allowed Louisiana to have a robust telework program (discussed in greater detail in Workflow Process below).

Implementation of ECR fosters better accuracy and timeliness of determinations, more flexible workloads, and better customer service. With all case information accessible to customers online, inquiries can be resolved quickly, application processing can proceed without eligibility staff involvement, and supervisors can conduct quality control.

Express Lane Eligibility (ELE): Included as an option for states under CHIPRA for enrolling children into Medicaid or CHIP, ELE is a technology-reliant strategy that has shown promise in increasing enrollment and retention in recent years.[34] ELE has been implemented by four Maximizing Enrollment states (Alabama, New York, Massachusetts and Louisiana), all with Maximizing Enrollment support. Fundamentally, ELE allows states to borrow the determinations made by other needs-based programs to determine eligibility for children in Medicaid or CHIP. Louisiana and Alabama implemented the policy for applications and renewals in Medicaid. Massachusetts only uses the policy for Medicaid and CHIP renewals. New York uses it during the transition between Medicaid and CHIP at renewal.

Two grantee states' adoption of ELE may have significant implications for managing the increased workload associated with the Medicaid expansion in 2014. CMS has approved federal waivers for both Alabama and Massachusetts to use ELE as a strategy for enrolling adults.[35] Alabama uses the policy to identify and enroll Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF)-eligible women into their Medicaid Family Planning Program. Massachusetts uses ELE to renew coverage for parents and children receiving subsidized health benefits.[36] States with currently low adult eligibility levels that choose to expand eligibility to 138 percent FPL as envisioned by the ACA, will likely experience an immediate and significant increase in enrollment. To the extent enrollment or renewal can be automated, states may significantly reduce the administrative burden of the expansion. In May 2013, CMS released guidance approving several temporary strategies states can use to streamline enrollment of Modified Adjusted Gross Income (MAGI)-eligible adult groups, including one that allows states to use SNAP income data to enroll non-elderly non-disabled persons into Medicaid without completing a separate Modified Adjusted Gross Income calculation and determination.[37] Either the ELE waiver or the temporary income determination option offer opportunities for states to use existing data from existing SNAP enrollment to support Medicaid enrollment in 2014 and beyond.

Workflow Management

The implementation of new technologies has prompted most Maximizing Enrollment grantees to rethink how the work of making eligibility and enrollment determinations is done. As a result, a few grantee states have redesigned business processes, changed job structures, and introduced new management tools and incentives to better fit their programs' new goals. While these changes are not always well documented or publicized, they can allow states and their workers to reap the greatest benefits from new technologies, including cost savings, greater worker efficiency, improved staff morale, faster benefit decisions, and a leaner business operation. Wisconsin's former Medicaid Deputy Director and Maximizing Enrollment project lead James Jones once said the challenge for states in implementing new technology was to "not pave over cow paths." States needed to allow themselves the freedom to invent new, different and more modern ways of doing business rather than simply incorporating old, outdated, and unnecessary processes into an electronic environment. Maximizing Enrollment grantees have employed a number of innovative strategies to rethink their work practices and structures to keep pace with technology.

Business Processes to Manage Work: Maximizing Enrollment states with the greatest change in their use of technology before and during the grant period also experienced some of the greatest shifts in how they approached their work processes. When Utah implemented its new eRep eligibility system in 2009, the state faced multiple challenges: more work coming in, significant changes in how work was being done, new leadership for the state's eligibility agency, the Department of Workforce Services (DWS), and a sizeable backlog of cases. Leaders quickly realized their first priority was to figure out how to streamline the workflow process for staff and use new technologies to lesson staff burden. With support from the governor and partner agencies like the Department of Health, DWS worked to define their management tools and developed a "throughput operating strategy" that would focus on "feeding the control point" – the eligibility worker – to maximize the worker's capacity to move cases to complete decisions. The state developed tools, like the "full kit" approach that informs eligibility workers when cases assigned to them have all the information and documentation needed for a decision, and used eChat and electronic notices to help consumers quickly resolve issues and respond with information when needed. Using these and other tools that enhanced eRep, Utah was able to eliminate the backlog of cases, manage an increasing workload of cases with fewer staff, and bring the timeframes for outstanding tasks down to 10-15 days from a previous maximum of 108 days.

Virginia's CHIP agency has also made major changes to business processes as the state has assimilated new technologies. Virginia also found the movement to online and phone processes required them to move from case management (where one worker "owns" a case and works it exclusively) to a "production work" mindset (where multiple workers can work a case, performing case tasks as needed to help get the case to a final decision when it is ready to work). Responding to the new challenge of not being able to see and directly monitor the paper case files to determine workflow needs, Virginia adopted a "Paperless Workflow" system to manage their work.

As noted above, Alabama's CHIP agency has also adopted a document imaging and workflow management system, that helps them monitor applications coming in and assign work out to staff based on need and work burden. Before implementing this system Alabama used paper-based applications and had only informal, manual tracking systems in place to monitor application processing. With the new system, Alabama's CHIP program increased its ability to monitor the number of applications being submitted, track their progress, and assign and manage work associated with incoming cases. As a result of implementing this new system, Alabama's CHIP program is processing its applications faster and is better able to manage work to equalize work burdens among staff. Alabama CHIP reports that the new system enabled the state to reduce the number of days to process a Medicaid application from six to only one day and to reduce renewal processing from six days to two days (see Figure 5, below). Alabama has also developed quality

control measures and metrics to ensure that processing time is reported accurately and can be monitored. One key issue for the state has been ensuring that additional staff is trained to assist with scanning documents in case of vacancies or increased application volume so that the state can keep its processing time low.[38]

Figure 5: Alabama CHIP Average Processing Times Pre- and Post- Document Imaging and Workflow Management System

Average Processing Time (Days From Rcvd/Scan Date)	New apps	Medicaid	Renewals	All App Types
Post- Implementation of New CHIP E/E System (Jan 2010 – Aug 2011*)	6	6	6	6
Post-Implementation of Document Imaging/Workflow Management System (Jan 2012* – Feb 2013)	1	1	2	1

***Note:** The Document Imaging and Workflow System, while initially implemented in September 2011, was not fully implemented until January 2012; therefore processing time was excluded from these calculations from September through December 2012.

Source: Alabama Department of Public Health, data received from Maximizing Enrollment team, Bureau of Children's Health Insurance, *Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees*, April 5, 2013.

Workforce Structures and Roles: A number of Maximizing Enrollment grantees opted to rethink existing agency structures and worker roles and responsibilities in light of new technologies coming on line to support eligibility and enrollment work. New York has been gradually moving from a local, county-based approach to enrollment toward greater centralization of functions. New York began by centralizing the processing of renewals and offering a telephone renewal option in twelve counties. Telephone renewals are an option in 31 counties today. The state is centralizing the processing of applications for Insurance Affordability Programs (Medicaid, CHIP, and federal premium tax credits and cost-sharing reductions) beginning in October 2013. As part of this transition, the state has already hired a number of county eligibility workers into the state system to do this work and plans to transition many of the eligibility functions from county to state control over the next five years.

Utah also reorganized how eligibility work is done in the state. In anticipation of implementation of their eRep system in 2009, Utah transitioned from a region-based system to a state-based operational approach. After forming in-house work teams, the agency's leaders set a new organizational vision and goals. Their primary goals were to reduce costs, improve operations to be more competitive with private sector models and use technology to "virtually centralize" staff in county offices and work-at-home employees to better distribute work, provide access to comparable work tools and standardize consumers' experience of the program. Within six months, the eligibility agency reorganized into a state-based operational structure with four eligibility service centers, 36 offices, and 166 telecommuters. All staff are linked by a central phone line with interactive voice recognition software and all eligibility workers receive and process cases through eRep.

As part of this transition, Utah also completely restructured worker roles to better fit the needs of a technologically-enabled eligibility agency. The newly developed work teams realized that they needed to recreate positions to better match the types of work and different roles needed given the increase reliance on online casework. Agency leaders then required all agency employees including managers to reapply for the new positions and worked to match individuals with new positions based on skills and interests. While this process was described by Utah officials as "painful," only one of the state's hundreds of merit-based employees filed a grievance and no one was laid off, although some workers were reassigned. The staff was organized into teams (for Family, Aged, Blind and Disabled, CHIP, refugees, Long Term Care and waiver populations) to ensure that work would flow to the right staff for

casework needs. Even though caseloads have grown, fewer workers manage the entire caseload, error rates have dropped, and the cost to process each case has dropped from $45 to $35 per case.[39]

Louisiana has aggressively used telephone renewal as a tool to maximize renewals of eligible children in part by engaging their workforce and moving from a passive to proactive approach. As part of their reform efforts in the Covering Kids and Families program, Louisiana decided to engage their workers in identifying work flow barriers and recommending solutions that could be tested on a small scale, measured, and then expanded to more sites. This local empowerment and "plan, do, study, act" model, along with a shift from case-based to task-based approach, has helped Louisiana develop new strategies in its approach to renewal and has accomplished a significant reduction in denials of children eligible for coverage at renewal, from 22 percent in 2001 to less than one percent in 2011.

Management Tools and Incentives: Maximizing Enrollment grantees have used a number of inventive tools and incentives to manage workers in a paper-free environment. In Louisiana, the state created new ways to distribute cases on a monthly basis electronically and created new metrics to allow workers and managers to monitor and incent completion of work. Louisiana also uses a remote workforce, enabled in part due to the adoption of the ECR. Louisiana managers are able to monitor worker performance of case-based tasks at quarter-hour increments to ensure work is getting done, even when work is off site. Louisiana has a formal work from home policy that outlines worker rights and responsibilities. As a result of formalizing their policy, Louisiana has been able to transition 42 percent of its Medicaid eligibility workforce to remote status. This transition has saved the state money as the state has been able to close local offices, reduce its spending for office space and equipment, and improve worker productivity and retention. The state also reports improved worker morale due to the flexibility that remote work offers.

Utah has been piloting a "pay for performance" initiative on a voluntary basis to incent worker performance under an electronic work model. The state recognized that under the old system, workers have a disincentive to work harder since the reward for doing more work was just a greater workload. The agency leaders received permission to create a new model that would reward high performance with additional pay. To do this, the agency didn't fill eight vacant positions and used the extra funds to create an incentive fund. Agency managers created performance metrics with case processing expectations for workers on a monthly basis, based on average number of cases processed. Workers that participate in the pilot can earn financial bonuses for every pay period in which their work exceeds the performance standards, up to $8,000 in extra bonuses per year. Although the pilot started with only 45 staff, it now includes 400 workers due to increased demand for voluntary participation among workers. Workers participating have reported improved morale and appreciation for the bonuses.[40]

Lessons for Other States

Maximizing Enrollment grantee states have learned important lessons from their experiences on the leading edge of technological improvements that may offer value to other states as they enter this field more fully in preparation for implementation of the ACA's technology requirements. Key themes either reported or drawn from these states' experience are noted below.

Let Policy Drive the Technology

Many of the grantee states that experienced major, successful technological improvements said that their work had been driven by a policy goal to improve operational functioning. Louisiana Maximizing Enrollment project lead and Medicaid Deputy Director Diane Batts reported that they first developed their vision for transforming renewals through tools, including Express Lane Eligibility, then worked

with their IT experts to accomplish the vision. In past experiences, she reported, eligibility policy staff often felt like their capacity for change was constrained by what the IT experts said could be accomplished. In their work, Batts said, policy was going to "drive the technology" instead. In this way, technology became a lever to accomplish Louisiana's larger goal of improving retention of eligible children, rather than an end in itself. Other participating states, including Wisconsin, Massachusetts, Utah and Virginia, also reported a similar approach with successful outcomes. Given the rapid pace of reforms to implement the ACA, many states may feel pressure to pursue more off-the-shelf technological solutions, but the Maximizing Enrollment state experience underscores the value of making sure the technology is suited or adapted to meet states' goals.

Technology Does Not Eliminate the Need for "Human Touch"

Grantees that worked to simplify and automate the enrollment process learned that in many cases there is no replacement for the value of direct human contact. While Utah has seen increased productivity and streamlined processes and operations, its performance in enrolling and retaining children, while improved over the grant period, remains low compared to other states. One concern some state officials raised was that driving too much enrollment traffic online and removing direct human contact could be undermining their enrollment successes. While Utah does provide support through call centers and online chat, it does not provide as much direct in-person consumer assistance through application assisters as some of the other grantee states do.

Training In-House IT Staff Can Pay Significant Dividends

While many states tend to rely on outside technology support from vendors, a few of the Maximizing Enrollment states found they were able to reap significant rewards when they included and trained their own IT and policy staff on the new technologies being implemented. Utah had this experience when the state implemented its eRep system. When the state wanted to customize an IT solution to support using eRep, the state staff ended up helping to design and create support tools and interfaces for eligibility worker use. Utah also reported that their trained staff now review all proposed IT projects and can reject any that does not fit with Utah's vision and technology operations. In this way, the state has been able to maintain a unified technological approach that doesn't rely on too many complex structures and vendors for ongoing maintenance.

New Technologies Require New Approaches and Processes

Many grantee states reported having a realization, either before or after implementation of a new technology, that business operations needed to change substantially to take their new environment into account. Rebecca Mendoza, Virginia's CHIP and Maternal and Child Health Director and Maximizing Enrollment project lead, articulated the challenge of managing what had previously been a paper-based eligibility production in an electronic environment, asking if the paper is "out of sight," are worker's caseloads "out of mind"? Louisiana experienced the same challenge and, due in part to its innovations in managing work electronically, was able to transition to a remote workforce model that allows 42 percent of its workforce to work off site, which has saved the state in office space and equipment costs and improved worker retention and morale.

Involve Local Staff in the Change Process

Grantee states can attest to the value of involving local staff in the process of planning for and implementing change. Louisiana found that involving local staff offices prompted creativity, improved morale and resulted in greater ownership and understanding among all staff about the reasons for change. Virginia has also worked to include local offices as they look to implement ACA-driven changes to ensure workers on the front lines understand change drivers and expectations as they evolve. Utah also shared that "change challenges morale." States implementing major technological improvements will want to anticipate morale challenges with approaches that will improve direct communication with front-line workers and ensure that workers understand their new roles and contribution towards new technology so that workers don't end up feeling like it is them feel like the workforce itself is outdated.

Plan for Security Protections

Two of the grantee states experienced security breaches during the grant period. While both states had thought that their security protections were adequate before the breach, both regretted the absence of clearer protocols to protect sensitive information and not having a plan for post-breach management. The ACA requires states to implement more stringent security protections and to ensure that electronic data transfers are secure. States may also want to invest time in planning how to manage securing information in case of a breach and a solid communications plan for the public.

Leadership and Vision Are Essential

Grantees clearly benefited from strong leadership and vision articulated by their leaders to support implementation of new technology. As one state official in Utah observed, "nothing implements itself." New technology is complex and requires dozens of policy decisions to be implemented successfully. Having clear goals and principles to guide the change will ensure that the implementing team can stay on track. Strong leaders who can shepherd the team and support definitive and timely decision-making are essential to success. Having a clear governance structure to support decision-making and work, including incentives for cooperation among agencies that will need to work together to implement change, is also positive. One grantee also stressed the value of asking for what is needed to support new technology – whether from federal or state leaders. Utah cited their example of asking CMS for permission to implement electronic notices, which will now be required for all states under the recent proposed ACA eligibility guidance.

Change Takes Time

While new technologies may be implemented on a speedy timeframe, grantee state experience demonstrates that the process of real change in terms of worker culture and agency impact happens more slowly. Utah reported that it implemented the organizational restructuring needed to bring eRep online in six months, but it took about three years for the agency to truly assimilate the changes and normalize its work. Many of our grantees also reported finding that their technology solutions needed adjustments with implementation and talked about the value of listening to customers and frontline workers to understand better when and which adaptations are needed.

Future Directions

As states consider new opportunities to use technology to support more seamless and efficient eligibility, enrollment and retention practices in coming years, there are a number of additional strategies they may want to consider:

- **Outreach:** States will have new challenges and opportunities to confront as they work to identify and enroll the newly eligible into coverage programs and new technologies can aid their work. Groups like Enroll America are already planning to use publicly available consumer database information paired with sophisticated data mining algorithms to help them identify adults who are likely to be uninsured. States may want to adopt these technologies and use what they learn to engage in micro-targeting of likely uninsured through person- or area-targeted outreach or targeted media buys in certain parts of the state. States like Virginia are already using social media like Facebook and YouTube to drum up interest among teens in coverage programs like Medicaid and CHIP. Other states will likely want to explore social media as a way to reach and engage the public, especially millennials, in new coverage options.

- **Applications:** States are already considering developing special smart phone applications, including functions that allow individuals to apply for coverage and upload documentation with their phone. Ensuring that applications are accessible via smart phones is critically important, especially for racial and ethnic minority populations that are more likely to access the Internet using smart phones and other hand-held devices. According to research published in 2010 by the Pew Internet & American Life Project, nearly two-thirds of African-Americans (64 percent) and Latinos (63 percent) are wireless Internet users, and minority Americans are significantly more likely to own a cell phone than their white counterparts (87 percent of blacks and Hispanics own a cell phone compared with 80 percent of whites).[41] States will also want to be thinking about new ways to make application materials and assistance accessible in other languages and for individuals with disabilities. Secretary Sebelius announced in June of 2013 that the federally facilitated marketplace national call center will communicate in more than 150 languages, and CMS has separately disclosed that the electronic model application all states will be available in English and Spanish with an online companion tool in another seven languages. Federal assistance with qualified, expert translation of the application and culturally competent translation for all forms of assistance will be needed to ensure that limited English proficient applicants have equal access to the application process and, ultimately, coverage.

- **Enrollment:** For many states, selection of a health plan has not historically been well-connected to the eligibility determination process. Given the seamless approach to enrollment into coverage that states are planning to adopt, technologies that allow for automated plan selection based on applicant preference or default enrollment is a next frontier in state enrollment work.

- **Renewals and Transfers:** Once states have invested human capital into enrolling individuals into coverage, they will want to protect their investment to ensure that renewals or transfers of coverage due to a change in eligibility are as seamless as possible. To that end, it will be vitally important for states to invest in new system interfaces and new technological tools that make the process of renewing or transferring as easy as possible, both for consumers and for

workers. Another area of work for states and federal agencies is ensuring the complete interoperability and capacity to exchange information, not only between states and the federally facilitated marketplace or the federal data hub, but also across state eligibility systems, so that individuals who move across state lines can be enrolled quickly.

Federal and state policymakers can also take action to ensure that investments in technology improve enrollment and promote efficiencies. First and foremost, states and federal officials will want to convene together to learn from their early experiences, share and document best practices, and promote adoption of successful strategies. Given the diversity of state progress and approaches, providing opportunities for peer-learning will improve efficiencies by ensuring that states don't need *to* recreate the technological wheel. CMS is already doing this through learning collaboratives and a shared cloud-based space for posting electronic artifacts, but increased direct engagement of all states at learning conferences and webinars will be needed in the coming years to maximize opportunities for success by states and federal agencies.

States and federal agencies can also benefit from a more focused approach to learning about the end user experience of the eligibility and enrollment process. While many Maximizing Enrollment states have used focus groups to support this end, it will be critical for states and federal agencies to invest resources into data collection and evaluation to learn as much as possible about how well the process is working for the end user. California's recent series of evaluations on the Health-E-App program is a great example of the value of data collection and its impact for policymakers. In that evaluation, California has already learned that online applications can draw in more affluent and Internet-savvy consumers without much additional outreach but that other applicants, including lower-income applicants, previously uninsured applicants, and those that predominantly speak Spanish, have been less likely to apply online without additional outreach. In order to be able to monitor and learn about user experience, states first have to have metrics in place to measure utilization and performance. Foundations and research organizations can also inform the dialogue by undertaking projects to shed light on the impact of technology for end users. The topic of performance measurement metrics will be addressed more fully in a forthcoming Maximizing Enrollment paper addressing state strategies to manage policy and system changes.

Importantly, many state and federal agency investments in system change and new technologies primarily target eligibility of non-disabled, non-elderly individuals. As a result, there is a real risk that elderly and disabled applicants will be left with an antiquated, paper-laden process. States and federal officials may want to leverage new technologies and strategies to streamline eligibility and enrollment processes for elderly and disabled individuals, to ensure that Medicaid's modernization is program-wide.

Conclusion

As states prepare for the ACA-driven technology changes in how they conduct eligibility and enrollment operations in their health coverage programs, they can gain new insights from Maximizing Enrollment grantee states' experiences, innovations and lessons learned. These lessons represent a leading edge of what will likely be a new era of technology-based eligibility and enrollment strategies that will be widely tested across the nation with the implementation of the ACA in the coming decade.

While 2014 will be a year of significant change for states, experience with Maximizing Enrollment states demonstrates that this will be the beginning, not the end, of the learning curve. As states continue with their work, they should continue to invest in and reap the rewards from peer state learning and look for new opportunities to learn and grow as they forge a new vision for the future of eligibility and enrollment systems.

Notes

[1] Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, Final Rule, 76 Fed Reg 21950 (U.S. Department of HHS, April 19 2011, Preamble) at 21951. CMS further noted that "these systems transformations should be undertaken in full partnership with Exchanges in order to meet coverage goals, minimize duplication, ensure effective reuse of infrastructure and applications, produce seamless enrollment for consumers, and ensure accuracy of program placements."

[2] It is worth noting that these barriers to system modernization have been very common among all states and are not unique to Maximizing Enrollment states.

[3] Jennifer Edwards et al, Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States, (Washington, DC: National Academy for State Health Policy and The Robert Wood Johnson Foundation, 2010), 3.

[4] Jennifer Edwards et al, Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States, 37-38.

[5] Beth Morrow and Julia Paradise, Explaining Health Reform: Eligibility and Enrollment Processes For Medicaid, CHIP, and Subsidies in the Exchanges (Washington, DC: Kaiser Family Foundation, 2010).

[6] Alice Weiss and Laura Grossmann, Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today (Washington, DC: National Academy for State Health Policy, 2011).

[7] Patient Protection and Affordable Care Act: Health Insurance Premium Tax Credit, Final Rule 77 Fed. Reg. 30377, May 23, 2012 (to be codified at 42 CFR § 433); United States, memorandum from Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid/CHIP Affordable Care Act Implementation: Answers to Frequently Asked Questions Availability of Enhanced Funding for IT Systems (90/10), Nov. 19, 2012. http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf

[8] Alice Weiss, Abby Arons and Julien Nagarajan, States' Medicaid ACA Checklist for 2014, (Washington, DC: State Health Reform Assistance Network, 2013).

[9] 47 States have either submitted or received approval of an advanced planning document to implement a major Medicaid eligibility system overhaul and most states (82%) had already begun work at the time the survey was completed in January of 2013. Martha Heberlein et al., Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013 (Washington, DC: Kaiser Family Foundation, 2013),13.

[10] Virginia halved its percentage of new applications denied due to an incomplete application submission, from 18% of all new applications received in June of 2010 to only 8% in July of 2011. In July of 2010, Virginia implemented e-signatures and online submission of documentation to support enrollment. While it is unclear whether there is a causal relationship between the policy and the impact on denials, it seems likely that some of the decline in denials may be due to the increased accessibility of online application completion through the use of these new technologies. Rebecca Mendoza. PowerPoint Presentation. "Getting in the Act? The State of State Implementation of Health Care Reform: Virginia's Experiences Using Technology to Streamline Enrollment." Uploaded to StateRefor(u)m, October 11, 2011. http://www.statereforum.org.

[11] Oklahoma's experience with online enrollment demonstrates that consumers will use this increased accessibility where the opportunity exists – in calendar year 2011, a quarter of all online applicants filed their applications during evening and weekend hours. Alice M. Weiss, "Hard Work Streamlining Enrollment Systems Pays Dividends to the Sooner State," Health Affairs 32, no. 1 (Jan 2013): 8.

[12] All of the six states that provide consumer-facing online applications except one (Illinois) accept electronic signatures. Two more states (Massachusetts and New York) allow electronic submission of applications through application assisters.

[13] Three of the five states that have implemented online renewal (Alabama, Utah and Virginia) implemented or improved access during the grant period. An additional grantee state (New York) developed an online renewal tool during the grant period. This tool is used by their centralized Enrollment Center to process renewals in 31 counties.

[14] Rebecca Mendoza, "Getting in the Act? The State of State Implementation of Health Care Reform: Virginia's Experiences Using Technology to Streamline Enrollment", slide 16.

[15] Asian & Pacific Islander American Health Forum, letter from Centers for Medicare & Medicaid Services, Department of Health & Human Services, April 22, 2013. http://www.healthlaw.org/images/stories/CMS LEP letter-05052013214435.pdf

[16] United States, Tri-Agency Letter from The Department of Health and Human Services and The Department of Agriculture, Cost Allocation of Information Technology Systems, Jan 23, 2012; Patient Protection and Affordable Care Act: Medicaid Program: Eligibility Changes Under the Affordable Care Act, Final Rule 77 Fed. Reg. 17144, March 23, 2012 (to be codified at 42 CFR § 431, 435, and 457).

[17] A number of states' use of telephonic applications and renewals are limited and not as expansive as what will be required under the ACA in 2014. Illinois' telephonic application requires applicants to sign and submit a signature page and both applications and renewals require paper documentation of any eligibility issue that cannot be verified electronically. Louisiana applicants must follow up with a written signature until the new application is ready for signature. New York is piloting telephonic renewal through a centralized enrollment center, and now exists in 31 counties. Utah provides assistance in completing online applications over the phone but requires a signature to be submitted and does not use a telephonic signature process. Virginia's telephonic applications are only accepted through calls to their Central Processing Unit, not through local departments of social services.

[18] Alabama reported that 163 enrollees attempted to renew by phone from March 2011 until May 2013 as part of a pilot program soliciting 500 enrollees to renew coverage. Of these 163 enrollees, 60 percent (97 enrollees) successfully renewed, 15 percent (25 enrollees) were income eligible for Medicaid and referred for enrollment, about 10 percent (17 enrollees) did not successfully renew because they were ineligible or hadn't paid their premium, and 15 percent (24 enrollees) failed to complete the process. Alabama Department of Public Health, data received from state Maximizing Enrollment team, Bureau of Children's Health Insurance, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees, April 5, 2013.

[19] Ibid. Note that Alabama has not advertised the availability of telephonic renewal beyond the pilot group.

[20] Impact of Telephonic Signature on CPU Call Center, Submission from Virginia. Kate Honsberger, email to Maureen Hensley-Quinn, April 2, 2013.

[21] Katie Baudouin, Christina Miller, Rachel Dolan, Designing Consumer Assistance Programs: Resources from the Field, (Washington, DC: State Health Reform Assistance Network, 2013); Alice Weiss, Abby Arons and Julien Nagarajan, States' Medicaid ACA Checklist for 2014.

[22] Massachusetts Executive Office of Health and Human Services. "Viewing Health Assistance Benefit Information." Retrieved April 11, 2013. http://www.mass.gov/eohhs/consumer/basic-needs/vg/map/viewing-health-assistance-benefit-information.html.

[23] State of Utah. MyCase one-pager information sheet. Uploaded to StateRefor(u)m, June 21, 2012. http://www.statereforum.org.

[24] Utah Department of Workforce Services, "3rd Party Provider Services." Retrieved June 6, 2013. http://jobs.utah.gov/occ/occ2/forproviders/mycase3party.pdf

[25] Under federal guidance, states must ensure applicants have the ability to designate an individual or organization to act as an authorized representative, either at the time of application or at any point thereafter. CMS intends to include the ability to designate an authorized representative on the single streamlined application but states may include this on alternative applications as well. Court orders, powers of attorney, and other legal documentation can also be used to designate a representative. Both the applicant and the representative must have the ability to terminate the relationship as they wish and all representatives must adhere to confidentiality and data security standards. U.S. Department of Health and Human Services, Federal Register 78, no .14 (January 22, 2013).

[26] Tricia Cox. PowerPoint Presentation. "eNotices & eAlerts." Presented at the State-to-State Exchange, Maximizing Enrollment, Salt Lake City, May 17, 2012.

[27] State of Utah, CMS Letter of Approval for eNotice Pilot. Uploaded to StateRefor(u)m, June 25, 2012. https://www.statereforum.org/sites/default/files/cms_enotice_waiver_1.pdf

[28] Julie Silas and Christina Tetreault, Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage?, (San Francisco, CA: Consumer Union, 2011).

[29] Tricia Brooks and Jessica Kendall, Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and the Exchanges, (Washington, DC: Maximizing Enrollment, 2012). Several states are planning to build chat functionality into their new eligibility systems. Additionally, at least three states, Arizona, California, and New Mexico have included it in their Exchange plans.

[30] Greg Paras. PowerPoint Presentation. "Online Chat Overview." Presented at the State-to-State Exchange, Maximizing Enrollment, Salt Lake City, May 17, 2012.

[31] Tricia Brooks and Jessica Kendall, Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and the Exchanges.

[32] State of Utah, eFind one-page information sheet. Uploaded to StateRefor(u)m, June 21, 2012. http://www.statereforum.org.

[33] Alabama Department of Public Health, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll,

[34] Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future, (Washington, DC: State Health Reform Assistance Network, 2012).

[35] Though in recent years CMS has been supportive of waivers to use ELE for adults, recent comments from the agency indicate that that support is softening.

[36] Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future.

[37] Center for Medicare and Medicaid Services, State Health Official Letter: SHO#13-003, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, May 17, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf

[38] Alabama Department of Public Health, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll, 4-5.

[39] For more information on Utah's approach to Workforce Culture Change, see Nicole Dunifon, IT Innovations One Piece of the Puzzle: A Look at Utah's Workforce Culture Change, (Washington, DC: Maximizing Enrollment, Forthcoming).

[40] Ibid.

[41] Aaron Smith, Mobile Access 2010 (Washington, DC: Pew Internet & American Life Project, 2010).

Appendix: Maximizing Enrollment Grantee State Adoption of Enrollment and Eligibility Technologies

Topic	AL	IL	LA	MA	NY	UT	VA	WI
Application/Renewal Technologies								
Online application/ e-signature	✔	✔	✔+			✔	✔	✔
Online renewal	✔		✔		+	✔	✔+ (C)	✔
Telephonic application/renewal	✔	✔	✔		✔□(M)[1]	✔	✔+[2]	✔
Customer Interfaces								
E-notices/texts						✔+	✔+	
Customer-facing accounts (including benefit status, report changes, viewing notices)	✔+ (M)			✔		✔+	✔	✔
System Improvements								
Electronic verification	✔(C)	✔	✔	✔	✔	✔+	✔□(C)	✔
Electronic case records			✔			✔	✔□(C)	✔
Express lane eligibility	✔□(M)[3]		✔+ (M)[4]	✔+[5]	✔□(M)[6]			
Electronic Document Management	✔(C)		✔	✔+		✔	✔(C)	✔
Workforce Management								
Paperless workflow			✔+				✔(C)	✔□
Centralizing processes/ rethinking work in light of technology			✔	✔	+	✔	✔(C)	

(Unless specified otherwise, this chart assumes these improvements apply to children, parents, and caretaker relatives)

✔□ - Implemented before or outside Maximizing Enrollment support
✔+ - Implemented with Maximizing Enrollment support
\+ - In progress
(M) - Implemented in Medicaid only
(C) = Implemented in CHIP only

[1] Only implemented in Medicaid and for certain counties.
[2] Virginia does telephonic renewals for both CHIP and Medicaid, but telephonic applications are used for CHIP only and telephonic signature only for applications submitted through CHIP Central Processing Unit, not to local offices.
[3] Alabama's ELE policy covers enrolling and renewing SNAP children and SNAP and TANF-eligible women eligible into the Family Planning program
[4] Louisiana's ELE policy covers enrolling SNAP-eligible children into Medicaid.
[5] Massachusetts has implemented ELE for children and parents with incomes up to 150 percent FPL.
[6] New York's ELE policy covers transitioning Medicaid- and CHIP-eligible children into either program when income changes.