Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

December 29, 2008

Michael Marshall
Secretary of Senate
State Capitol
LOCAL

Mark Brandsgard
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Mr. Brandsgard:

Enclosed please find copies of a report to the Governor and General Assembly relative to maximization of enrollment and retention of children in the Medicaid and ***hawk-i*** programs.

These reports were prepared pursuant to directive contained in Section 15 of H.F. 2539. These reports describe the process utilized to gather input, develop recommendations and reflect several strategies designed to improve access to and retention in the Medicaid and ***hawk-i*** programs.

The Department, in partnership with the Iowa Child and Family Policy Center, planned and organized a one and one-half day conference to bring together entities from throughout Iowa committed to the health care of Iowans and nationally recognized experts in health care reform from across the country. Information was shared, ideas were brainstormed and recommendations were ultimately made. Some ideas and concepts did not rise to the level of becoming a recommendation, not because of their merit, but because they may be considered too controversial or require further study. However, these issues are also discussed within the report.

As reflected by the comprehensiveness of the report, the Department collaborated in good faith to develop recommendations designed to maximize enrollment of children in the Medicaid and ***hawk-i*** programs. However, given the current budget challenges, the Department is not making any recommendations at this time. Iowa was recently ranked as second in the United States as having the lowest uninsured rate for children and it is important that we do not lose ground in this ranking. Rather than being defined as 'recommendations', the ideas put forth within the report are defined as 'options' that warrant consideration by the Governor and General Assembly.

Options are categorized within three primary areas: 1) coverage, 2) application and eligibility reviews/renewals, and 3) administrative enhancements. If you have any questions about the contents of the report please do not hesitate to contact me.

Sincerely,

Molly Kottmeyer
Legislative Liaison

Enclosure

cc: Governor Culver
Legislative Service Agency
Kris Bell, Senate Majority Caucus
Peter Matthes, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus

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The Honorable Chester J. Culver
Governor, State of Iowa
State Capitol
LOCAL

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cc: Michael Marshall, Secretary of Senate
Mark Brandsgard, Chief Clerk of the House

Maximizing Enrollment and Retention of Children in the Medicaid & *hawk-i* Programs

Report of the Iowa Department of Human Services
to the Governor and General Assembly

December 2008

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Report of the Iowa Department of Human Services
to the Governor and General Assembly

Executive Summary

The 2008 Iowa Legislature directed the Department of Human Services (DHS) to research and submit a report to the Governor and General Assembly on ways to maximize enrollment and retention of children in the Medicaid and Healthy and Well Kids in Iowa (***hawk-i)*** programs.

This report describes the process utilized to gather input, develop options and identifies several strategies designed to improve access and retention in the Medicaid and ***hawk-i*** programs for uninsured eligible children.

Improving application and enrollment processes is critical to providing basic health care for eligible Iowans. Numerous studies show that the consequences for children not having health insurance include:

Uninsured children are **less** likely to:

- Receive medical care when sick or injured,
- Have a regular source of health care,
- Be fully immunized,
- Have well-child visits,
- Obtain dental care

Uninsured children are **more** likely to:

- Miss more school,
- Be more seriously ill upon admission to a hospital,
- Use more resources during hospitalization, and
- Suffer from higher mortality rates while in the hospital.

Barriers to Enrollment

Expanding health care coverage to uninsured children has gained national attention and momentum in recent years. Besides simply expanding income limits to make more children eligible, more attention is being paid to the complex policies and procedures used to establish eligibility and the barriers these policies present in keeping otherwise eligible children from attaining coverage.

Studies have shown that the burden to provide numerous documents to prove eligibility causes a significant number of 'administrative denials' that result in children not being

able to access benefits to which they are otherwise eligible. In some cases, families must apply multiple times before they are able to successfully navigate the system and attain eligibility. Once they are enrolled, they may subsequently lose coverage because of onerous policies and procedures required to prove ongoing eligibility. The 'churning' of children in and out of program eligibility results in breaks in continuity of coverage, increased usage of emergency rooms and increased administrative costs associated with processing multiple applications. Administratively, it is less costly to provide continuous coverage to a child than to process a new application once coverage has been lost.

To the greatest extent possible, the Department has taken a holistic approach to simplifying and streamlining policies across all programs. This is in recognition that families apply for and eligibility workers process applications for multiple programs. Simplifying eligibility policies and keeping policy and processes as consistent as possible across all programs is critical to minimize family confusion about what is needed to establish eligibility, reduce administrative denials, and reduce churning in and out of programs.

However, simplifying policies and procedures must be done hand-in-hand with an effective marketing strategy to maximize enrollment. In the past, eligibility for Medicaid for families and children was tied to getting cash assistance. This resulted in Medicaid often having the stigma of being linked to 'welfare'. Being 'on welfare' has proven to be a barrier for some families in applying for medical coverage for their children. Marketing programs as healthcare for children in working families and not welfare for poor families is a critical component in successfully enrolling children.

Process for Developing Options

DHS, in partnership with the Iowa Child and Family Policy Center, planned and organized a conference to bring together entities throughout Iowa committed to the health care of Iowans and recognized experts in health care reform from across the country.

Billed as a Health Care Summit, the conference was a two-day event. Presenters included Donna Cohen Ross from the Center on Budget and Policy Priorities; Cindy Mann, Liz Arjun, and Tricia Brooks from Georgetown Center for Children and Families in Washington D.C.; Charlie Bruner and Carrie Fitzgerald from Iowa Child and Family Policy Center; Ruth Kennedy, Director of Louisiana SCHIP program called LaCHIP; and Anita Smith from DHS. Ruth Kennedy, Director of Louisiana SCHIP (LaCHIP) program referred to the meeting as a "national caliber conference".

The following list reflects the options from the summit and other information gathered by the Department. Options fall into one of three categories; Coverage, Application & Eligibility Reviews and Renewals, and Administrative Enhancements. Each of the options is discussed in detail below:

- Implement Presumptive Eligibility for Children in Medicaid
- Provide Dental-Only Coverage for Underinsured Children
- Provide Medicaid to Parents with Income up to 100% of the Federal Poverty Level
- Cover All Kids
- Expand Medicaid for Pregnant Women to 300% of the Federal Poverty Level
- Define Medicaid & ***hawk-i*** Coverage as Creditable Coverage for Portability into the Individual Market
- Implement Single Pay Stub Income Verification
- Average 3 Years' Income for Self-Employed Families to Establish Eligibility
- Express Lane Eligibility – Consider an Application for Free & Reduced Price Meals as an Application for Medicaid
- Express Lane Eligibility - Food Assistance and Family Investment (FIP) Categorical Eligibility for Medicaid
- Improve Renewal Processes
    - Allow More Time to Renew Medicaid Coverage
    - Implement Small-Scale Testing with Low-Risk Families for Renewals
    - Implement Telephonic Renewal Processes
    - Implement Passive Renewals
- Increase/Improve Technology
    - Electronic Verification of Vital Events (EVVE)
    - Enhanced WORK NUMBER
    - Data Brokering Systems – eFIND
    - Customer Portals

Several ideas were proposed at the Health Care Summit that merit further consideration but, at this point in time, are not being included as options. Each is discussed within the report.

Maximizing Enrollment and Retention of Children in the Medicaid & *hawk-i* Programs

Report of the Iowa Department of Human Services
to the Governor and General Assembly

Background

The 2008 Iowa Legislature directed the Department of Human Services (DHS) to research and submit a report to the Governor and General Assembly on ways to maximize enrollment and retention of children in the Medicaid and Healthy and Well Kids in Iowa (***hawk-i)*** programs.

Specifically, the *Report of the Conference Committee on House File 2539* requires:

H.F. 2539 Sec. 15. MAXIMIZATION OF ENROLLMENT AND RETENTION – MEDICAL ASSISTANCE AND ***hawk-i*** PROGRAMS.

1. The department of human services, in collaboration with the department of education, the department of public health, the division of insurance of the department of commerce, the ***hawk-i*** board, consumers who are not recipients of or advocacy groups representing recipients of the medical assistance or ***hawk-i*** program, the covering kids and families coalition, and the covering kids now task force, shall develop a plan to maximize enrollment and retention of eligible children in the ***hawk-i*** and medical assistance programs. In developing the plan, the collaborative shall review, at a minimum, all of the following strategies:
    a. Streamlined enrollment in the ***hawk-i*** and medical assistance programs. The collaborative shall identify information and documentation that may be shared across departments and programs to simplify the determination of eligibility or eligibility factors, and any interagency agreements necessary to share information consistent with state and federal confidentiality and other applicable requirements.
    b. Conditional eligibility for the ***hawk-i*** and medical assistance programs.
    c. Expedited renewal for the ***hawk-i*** and medical assistance programs.

This report describes the process utilized to gather input, develop options and identifies several strategies designed to improve access and retention in the Medicaid and ***hawk-i*** programs for uninsured eligible children.

Impact on Children of Being Uninsured

Improving application and enrollment processes is critical to providing basic health care for eligible Iowans. Numerous studies show that the consequences for children not having health insurance include:

Uninsured children are **less** likely to:

- Receive medical care when sick or injured,
- Have a regular source of health care,
- Be fully immunized,
- Have well-child visits,
- Obtain dental care

Uninsured children are **more** likely to:

- Miss more school,
- Be more seriously ill upon admission to a hospital,
- Use more resources during hospitalization, and
- Suffer from higher mortality rates while in the hospital.

In addition to the burden on these children and their families, there are costs to the health care system and society for providing primary care services to the uninsured in expensive hospital emergency room settings.

Overview of Iowa's Programs

The Medicaid and ***hawk-i*** programs are the primary systems utilized for providing healthcare coverage to low-income uninsured children. The Department of Human Services administers both programs.

Medicaid is authorized under Title XIX of the Social Security Act. Some Medicaid coverage groups and services are mandatory while other coverage groups and services may be provided at state option. In Iowa, Medicaid is available to children in families with income up to 133 percent of the Federal Poverty Level (FPL). In addition to children, the Iowa Medicaid program covers Iowans who are aged, disabled, pregnant, parents with children, adults without children, and women who have been screened and diagnosed through the Breast and Cervical Cancer Early Detection Program and are in need of treatment. Medicaid is funded by a combination of federal (62%) and state (38%) funds.

The ***hawk-i*** program is authorized under the State Children's Health Insurance program (SCHIP); Title XXI of the Social Security Act. It is a 'stand-alone' program modeled after private health insurance. The ***hawk-i*** program covers uninsured children under the age of 19 who are not eligible for Medicaid and whose family income is between 133 and 200 percent of the FPL. As with Medicaid, funding is a combination of federal (75%) and state (25%) funds.

See Attachment A: Iowa's Healthcare Programs for Non-Disabled Children

Barriers to Enrollment

As demonstrated by the passage of H.F. 2539, expanding health care coverage to uninsured children has gained national attention and momentum in recent years. Besides simply expanding income limits to make more children eligible, more attention is being paid to the complex policies and procedures used to establish eligibility and the barriers these policies present in keeping otherwise eligible children from attaining coverage.

Studies have shown that the burden to provide numerous documents to prove eligibility causes a significant number of 'administrative denials' that result in children not being able to access benefits to which they are otherwise eligible. In some cases, families must apply multiple times before they are able to successfully navigate the system and attain eligibility. Once they are enrolled, they may subsequently lose coverage because of onerous policies and procedures required to prove ongoing eligibility. The 'churning' of children in and out of program eligibility results in breaks in continuity of coverage, increased usage of emergency rooms and increased administrative costs associated with processing multiple applications. Administratively, it is less costly to provide continuous coverage to a child than to process a new application once coverage has been lost.

In addition to Medicaid and ***hawk-i***, families are often eligible for, or apply for, multiple programs such as Food Assistance, Child Care Assistance and Temporary Assistance to Needy Families cash assistance (called the Family Investment Program (FIP) in Iowa). Each of these programs has their own set of eligibility policies that may lead to further confusion for families about what they need to do to qualify.

To the greatest extent possible, the Department has taken a holistic approach to simplifying and streamlining policies across all programs. This is in recognition that families apply for and eligibility workers process applications for multiple programs. Simplifying eligibility policies and keeping policy and processes as consistent as possible across all programs is critical to minimize family confusion about what is needed to establish eligibility, reduce administrative denials, and reduce churning in and out of programs.

However, simplifying policies and procedures must be done hand-in-hand with an effective marketing strategy to maximize enrollment. In the past, eligibility for Medicaid for families and children was tied to getting cash assistance. This resulted in Medicaid often having the stigma of being linked to 'welfare'. Being 'on welfare' has proven to be a barrier for some families in applying for medical coverage for their children. Marketing programs as healthcare for children in working families and not welfare for poor families is a critical component in successfully enrolling children.

Simplification and Expansion Accomplishments to Date

With the passage of the Personal Responsibility and Work Opportunity Act (PRWOA) in 1996 that 'delinked' Medicaid from cash assistance and the SCHIP legislation in 1997, states were given more flexibility than ever before to simplify policy for medical programs. The following list illustrates how Iowa has taken advantage of this new flexibility to incrementally improve health care policies.

- Medicaid expanded to 133% of Federal Poverty Level for children & to 185% of Federal Poverty Level for infants (7/98)
- ***hawk-i*** implemented to cover children up to 185% of Federal Poverty Level (1/99)
- Medicaid asset test eliminated for children (7/99)
- Medicaid face-to-face interviews for applications were eliminated
  - For children (7/99)
  - For adults (8/07)
- ***hawk-i*** expanded to 200% of Federal Poverty Level for children & Medicaid expanded to 200% of Federal Poverty Level for infants (7/00)
- 20% earned income deduction for ***hawk-i*** to match Medicaid policy (7/00)
- Monthly reporting of income eliminated for Medicaid (10/00)
- Medicaid eligibility reviews extended from 6 months to 12 months (10/00)
- Online application for ***hawk-i*** (1/04)
- Automated referral to ***hawk-i*** for children canceled from or denied Medicaid due to family income exceeding Medicaid limits (7/04)
- Forms simplification project (2004)
- Outreach with Free & Reduced Meals programs through schools to identify children who may potentially be eligible for ***hawk-i*** or Medicaid (7/05)
- Children's Mental Health Waiver (10/05)
- Medicaid for Independent Young Adults (7/06)
- Vital Records match on birth records for citizenship verification for Medicaid (8/06)

- Medicaid earned income deduction increased from 50%to 58% for Family Medical Assistance Program (8/07)
- Monthly paper Medicaid ID card replaced with annual plastic card (8/07)
- Continuous eligibility for children in Medicaid (7/08)
- Statewide change reporting call center in operation (10/08)
- Policy revised to require the signature of only one parent on applications and renewals (11/08)

Pending Changes:

- Implementation of an on-line multi-program application (including Medicaid) with electronic signature (scheduled to be implemented 12/08)
- Implementation of the Family Opportunity Act to provide coverage to disabled children with family income up to 300% of Federal Poverty Level (1/09)
- Increase time allowed for families to renew eligibility to 30 days (Spring 2009)
- Expand ***hawk-i*** to 300% of Federal Poverty Level for children and Medicaid to 300% of Federal Poverty Level for infants (scheduled to be implemented 7/09)

Process for Developing Options

DHS staff began gathering data by reviewing numerous national reports, issue briefs, articles, researching the Internet, federal regulations, and state laws. Other states were contacted to get information on their experiences with various policies and what strategies worked or didn't work for them. Some of these experiences and strategies are discussed in more detail later in this report.

DHS, in partnership with the Iowa Child and Family Policy Center, planned and organized a conference to bring together entities throughout Iowa committed to the health care of Iowans and recognized experts in health care reform from across the country.

Billed as a Health Care Summit, the conference was a two-day event. Presenters included Donna Cohen Ross from the Center on Budget and Policy Priorities; Cindy Mann, Liz Arjun, and Tricia Brooks from Georgetown Center for Children and Families in Washington D.C.; Charlie Bruner and Carrie Fitzgerald from Iowa Child and Family Policy Center; Ruth Kennedy, Director of Louisiana SCHIP program called LaCHIP; and Anita Smith from DHS. Ruth Kennedy, Director of Louisiana SCHIP (LaCHIP) program referred to the meeting as a "national caliber conference".

During the two-day conference, strategies such as streamlined enrollment, express lane eligibility, passive and ex parte' renewals and presumptive eligibility were covered. Further information about these strategies is discussed throughout this report.

The first day addressed the importance of aligning health care benefits with private health coverage while remaining affordable to families. In addition, potential changes to cost sharing, co-payments, out-of-pocket expenses, and parental responsibility were discussed as viable options that Iowa could adopt to alleviate some of the costs of the Medicaid and ***hawk-i*** programs.

Day two of the conference addressed strategies to improve Medicaid and ***hawk-i*** retention as well as increase enrollment for children. An overview of the current enrollment process was explained. Simplified enrollment processes were discussed as well as policy changes that might result in more eligible children. Additionally, renewal procedures were examined to understand what works today and where changes might be needed. Presumptive eligibility for children was also discussed. There were three breakout sessions to discuss and recommend strategies on streamlined enrollment as well as presumptive eligibility for children, expedited renewal, and other options to increase enrollment and retention. Feedback was provided to the group at the end of the day.

See Attachment B: Agenda - SCHIP & Medicaid Summit: Maximizing Opportunities for Children in Iowa

What is Streamlined Enrollment or Express Lane Eligibility?

Streamlined Enrollment or Express Lane Eligibility (ELE) describes processes to easily identify and enroll eligible uninsured, low-income children. It is based on the fact that many eligible but uninsured children already participate in other need-based public programs such as the National School Lunch Programs, food assistance, WIC, or Head Start. Discussions of ELE often describe three levels of implementation:

1) Targeted Outreach ("starter" level) model - use income-tested public programs as a way to provide Medicaid/***hawk-i*** information to targeted uninsured children,
2) Streamlined Application ("intermediate" level) model - use information already collected on child's application for one program to provide income/information to Medicaid/***hawk-i***, and
3) Automatic Eligibility ("advanced" level) model - use child's enrollment in an income-comparable program to automatically enroll in Medicaid/***hawk-i***.

What are Provider Gateways?

In this strategy, healthcare providers assist people they see at their place of business by applying for Medicaid or ***hawk-i*** using the Internet or other technology and information provided by DHS.

Community partners (e.g. hospitals, doctors, WIC, visiting nurse services, Head Start, school and child care personnel) may need to be educated on the benefits of helping families apply for Medicaid and ***hawk-i*** online.

Recent upgrades to technology within DHS will allow applications to be submitted at any time with a single electronic signature. The general public who may have contact with uninsured low-income children will be able to easily access these technologies. Encouraging "provider gateways" to assist applicants ensures a complete application will be submitted, and may facilitate speedy payment for services.

Other States utilizing this methodology:

State	Process
California	School personnel assist in outreach through the National School Lunch Program (NSLP).
Hawaii	Outreach workers assist patients in hospitals & fax applications the same day. Newborn information provided to DHS immediately.
Illinois	Outreach more successful through medical providers than schools. Payment of $50 paid for each enrolled applicant.
Indiana	School personnel assists in outreach through the National School Lunch Program (NSLP).
Maryland	School personnel assists in outreach through the National School Lunch Program (NSLP).
Massachusetts	On-line enrollment tools allow providers to assist with applications.
Michigan	On-line application available. Outreach workers can assist those who don't have internet access.
North Carolina	Hospital ER assists with applications. Outreach worker follows up with family.
Pennsylvania	Helpline staff takes information by phone for application. Higher rate of completion.
Utah	School personnel assists in outreach through the National School Lunch Program (NSLP).

See Attachment C: Gateway Model

What is Presumptive Eligibility?

Presumptive eligibility is a process that allows immediate access to temporary health care services while a child's eligibility for ongoing coverage is being processed. Eligibility is based on the household's statements about who lives in the home and their income. States may require the family self-declare their citizenship status and identity. Presumptive eligibility is a benefit not only to citizen children, but, if the state chooses to not require a declaration of citizenship, also to immigrant or undocumented children who are not otherwise eligible, other than three-day emergency services.

Iowa currently has two presumptive eligibility programs for:

1. Pregnant women, and
2. Women who have been screened and diagnosed through the Breast and Cervical Cancer Early Detection Program (BCCEDP) and are in need of treatment for breast or cervical cancer or a precancerous condition.

Under the current programs, DHS contracts with certain providers to make presumptive eligibility determinations. These providers take applications, calculate family income, call DHS to check for current or past Medicaid eligibility and to get a State identification number for individuals they determine eligible. DHS staff enters the eligibility information into the presumptive system so that claims submitted for services during the presumptive period can be processed.

Eligibility begins the day the provider determines the person to be presumptively eligible and extends through the last day of the next month or until a decision is made on the application, if the application was forwarded to DHS. In some states this is done automatically. In others, a separate application must be filed. If the person does not follow through with filing a separate application, eligibility ends at the end of the presumptive period.

States that have implemented presumptive eligibility for children:

State	Process
Colorado	Providers are certified every 2 years. All presumptive applications are forwarded to DHS for a Medicaid eligibility determination.
Connecticut	Uses the SCHIP application. Requires self-declaration of both income & citizenship status. All applications are sent to Medicaid. State staff reviews eligibility immediately and mistakes are corrected. The provider completes no follow-up. Providers are certified and trained every 6 months.
Illinois	Presumptive eligibility is determined based on declared gross income. No information on citizenship/immigration status is requested.

State	Process
Kansas	Income is self-declared. Child must be citizen or meet qualified alien criteria. Sixty-two percent of applicants did not follow through with ongoing Medicaid. Clinics provide extra effort to help applicants and have an 80 percent approval rate. Recommends a web-based tool to determine presumptive eligibility. Also to certify staff and re-certify annually.
Louisiana	Income is self-declared. Uses standard Medicaid application. Does not require applying for ongoing Medicaid.
Maryland	No presumptive because application processing is done quickly.
Massachusetts	Income is self-declared for initial determination but verification is required within 60 days. Approves presumptive 10 days prior to the application date. Cannot have health insurance. Allowed once in a 12-month period.
Michigan	Medicaid application used and is sent to DHS. Applicant required to self-declare citizenship and alien status. If applicant appears not eligible for ongoing coverage, then not eligible for presumptive. Has a central processing system. State staff reviews each determination. Training is provided and providers are certified.
Missouri	Started with four children's hospitals and expanded to FQHC and rural health centers as providers.
Nebraska	Had presumptive 1997 to 2003 and it ended due to funding. Citizenship and alien status were self-declared and non-qualified aliens did not qualify. Had 76 percent approval rate for ongoing Medicaid that increased to 86 percent when follow-up was completed.
New Hampshire	Medicaid application used. Outreach staff attended training and did eligibility determinations. Consecutive presumptive periods are prohibited.
New Jersey	All eligibility determinations are reviewed for accuracy. Information is self-declared. Applications are forwarded to Medicaid.
New Mexico	Schools are Medicaid providers and enroll children as presumptively eligible. Other providers also can make presumptive eligibility determinations. Medicaid application is used and forwarded to State staff for ongoing determination. Citizenship and alien status are self-declared. After presumptive is approved, the presumptive provider requests verification and sends with application to DHS. Training for providers and certification of agency done annually. Allowed one presumptive period in 12 months.
New York	Citizenship and alien status are self-declared. Allowed one presumptive period in 12 months. Comprehensive training is

State	Process
	given to providers. A screening form is completed before the application. Provider assists applicants with obtaining documentation for DHS after the presumptive approval.
Wisconsin	Uses SCHIP application for presumptive. Implemented 2-1-08.

What are Ex Parte' and Passive Renewals/Redeterminations?

Redetermination or renewal is the process of examining the file of a Medicaid member or ***hawk-i*** enrollee to decide whether they continue to be eligible.

Ex parte' is the process of examining eligibility without asking the family for additional information. States may be able to establish ongoing eligibility by matching information from existing data sources or information contained in the eligibility file that was provided for other programs.

Passive renewal is a simplified and seamless approach to performing annual Medicaid and SCHIP eligibility reviews in order to maintain health coverage and eliminate churning as well as maintaining program integrity and accuracy. In theory, a state could simply mail a renewal form to the family and ask them to respond only if there have been changes in the family's circumstances since the last review. If the family does not respond, the state assumes no changes have occurred and eligibility continues. Georgia implemented a passive renewal process for a short period of time but, due to budget constraints, abandoned the practice and implemented renewals with full income verification requirements.

Option Summary

The following list reflects the options from the summit and other information gathered by the Department. Options fall into one of three categories; Coverage, Application & Eligibility Reviews and Renewals, and Administrative Enhancements. Each of the options is discussed in detail below:

- Implement Presumptive Eligibility for Children in Medicaid
- Provide Dental-Only Coverage for Underinsured Children
- Provide Medicaid to Parents with Income up to 100% of the Federal Poverty Level
- Cover All Kids
- Expand Medicaid for Pregnant Women to 300% of the Federal Poverty Level
- Define Medicaid & ***hawk-i*** Coverage as Creditable Coverage for Portability into the Individual Market
- Implement Single Pay Stub Income Verification
- Average 3 Years' Income for Self-Employed Families to Establish Eligibility

- Express Lane Eligibility – Consider an Application for Free & Reduced Price Meals as an Application for Medicaid
- Express Lane Eligibility - Food Assistance and Family Investment (FIP) Categorical Eligibility for Medicaid
- Improve Renewal Processes
    - Allow More Time to Renew Medicaid Coverage
    - Implement Small-Scale Testing with Low-Risk Families for Renewals
    - Implement Telephonic Renewal Processes
    - Implement Passive Renewals
- Increase/Improve Technology
    - Electronic Verification of Vital Events (EVVE)
    - Enhanced WORK NUMBER
    - Data Brokering Systems – eFIND
    - Customer Portals

OPTION DETAILS

Coverage

Option 1. Implement Presumptive Eligibility for Children in Medicaid
Use the established DHS process and initially, limit to providers that currently make presumptive Medicaid eligibility determinations for pregnant women.

Use the ***hawk-i*** application as the presumptive application. Providers will screen for eligibility under Medicaid (133 percent of poverty) and ***hawk-i*** (200 percent of poverty). If a child appears to be income eligible for Medicaid, approve presumptive eligibility and forward the application for a formal eligibility determination to DHS. If a child appears to be over income for Medicaid, but eligible for ***hawk-i***, presumptive eligibility will not be approved but the application will be forwarded for a ***hawk-i*** eligibility determination.

Expand the provider network as issues are identified and corrected.

Closely monitor the take-up rate to identify how the SCHIP budget is being impacted.

Issues / Concerns

1. If a child is made presumptively eligible and does not ultimately become eligible for ongoing coverage, the cost of care received by the child comes from the state's SCHIP allotment. This is true regardless of whether the child was determined presumptively eligible for Medicaid or SCHIP. Since a state's SCHIP funding is capped, if a high percentage of children determined presumptively eligible for Medicaid do not become Medicaid eligible, the amount of available SCHIP funding for eligible children could be impacted. This is more of an issue for states with separate SCHIP programs, like Iowa, than those that merely have Medicaid expansions.

2. The ***hawk-i*** program is designed as a commercial insurance model. Under the structure of the current program, coverage begins the first day of the month after the month in which the application is filed. Participating health plans are paid a monthly premium to provide coverage. Implementing presumptive eligibility for the ***hawk-i*** program would require the development of a new payment structure for claims during the presumptive period.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Amendment to 249A of the Code of Iowa and an appropriation.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 IAC 75 and 76

To implement this change....		Comments (list legal cites if applicable)
Are changes to IT systems needed?	☒ YES ☐ NO	The current presumptive system (PRSM) will need modified to accept children. Changes are expected to be minimal but further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES ☐ NO	**Total State Dollars: $7 - $9M**
What is the length of time needed to implement this change?	12 months to promulgate rules, make necessary systems changes and train the presumptive eligibility providers.	
Other comments:	**Assumptions:** ▪ Iowa will initially utilize the same providers that are contracted to determine presumptive eligibility for pregnant women. ▪ An FTE for monitoring providers is a critical component to ensure the accuracy of the decisions and program integrity. If the provider network is expanded beyond those that currently determine presumptive eligibility, additional FTEs will be required. ▪ Presumptive eligibility providers will assist families with the application process for Medicaid (help with providing necessary verification.) ▪ The presumptive application will be a Medicaid application.	

Option 2: Provide Dental-Only Coverage for Underinsured Children through the ***hawk-i*** Program

Tooth decay is the most common chronic childhood disease. However, under current federal law, a child must be uninsured in order to participate in the state's SCHIP program. Therefore, children who have health insurance but no dental coverage are ineligible to participate in the program. Iowa and other states are advocating for federal authority as part of the reauthorization of the State Children's Health Insurance Program to implement dental-only coverage benefit plans. Unless the federal government provides authorizing legislation and an appropriation, this Option would have to be supported with 100 percent state funding.

Studies show that oral health is one of the most pressing needs for uninsured and underinsured children. According to a General Accounting Office report (GAO/HEHS-00-72), poor children have five times more untreated dental cavities than children in higher income families. Dental problems result in pain, infection, and millions of lost school days nationally each year. Left untreated, the pain and infection caused by tooth decay can lead to problems in eating, speaking and attention to learning.

In 2007, Dr. Peter Damiano of the University of Iowa Public Policy Center had the following observations in estimating the number of children who have health but not dental coverage:

> The closest information we have from the Iowa Child and Family Household Health Survey is that there are 22-23% of children with family income between 133-200% of the Federal Poverty Level (as self-reported by the parent) that have medical and not dental insurance.
>
> We are estimating that there are currently about 750,000 kids in Iowa. Therefore about 135,000 kids in the state are in families with income between 133 – 200% of Federal Poverty Level and about 30,000 (22.5%) have medical insurance but no dental insurance.

Income	% of Total Iowa Child Population	Estimated Number of Children with Health but no Dental Insurance
< 133% FPL	20%	(Medicaid Eligible)
134% - 200%	18%	30,000
201% +	62%	(No Data Available)

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Code Chapter 514I of the Code of Iowa and an appropriation
Are amendments to the administrative rules required?	☒ YES ☐ NO	441—Chapter 86
Are changes to IT systems needed?	☒ YES ☐ NO	The ***hawk-i*** third party administrator would need to make systems changes to accommodate an additional program. Further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES ☐ NO	**Total State Dollars: $3 - $3.5 M**
What is the length of time needed to implement this change?	12 months to design the program, promulgate rules, amend contracts, and develop materials to inform the public about the new program.	
Other comments:	**Assumptions:** ▪ The Department's third party administrator for the ***hawk-i*** program would administer this program. ▪ The income limit would be the same as the ***hawk-i*** program (i.e. 300% of Federal Poverty Level) ▪ The dental benefit plan would be the same as that provided to children enrolled in the ***hawk-i*** program. ▪ Children who are eligible for Medicaid are not eligible for this program.	

Option 3: Provide Medicaid to Parents with Income up to 100% of the Federal Poverty Level

The Institute of Medicine concluded in a major 2002 report that health insurance is "a family matter."

- **Family coverage promotes child and family well-being**. Parents without health care coverage are less able to access care. When parents lack the medical care they need, their ability to work, support their families, and care for their children is compromised.

- **Parent coverage promotes children's coverage** Studies and state experience have consistently shown that covering parents promotes coverage and access to care for children. Low-income families with uninsured parents are three times as likely to have uninsured children compared to parents with private coverage or Medicaid. Studies show that when parents can also receive coverage, they are more likely to enroll their children.

Iowa currently has the option under federal Medicaid law (Section 1931 of the Social Security Act) to expand coverage for parents above federal minimum standards. There is no cap on the eligibility levels as long as a state is able to provide the matching funds. Currently, there are approximately 34,388 parents with income under 100% of the Federal Poverty Level who do not receive Medicaid but whose children are covered under Medicaid.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Amendment to 249A.3 of the Code of Iowa and an authorizing appropriation.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 – Chapter 75 of the Iowa Administrative Code.
Are changes to IT systems needed?	☒ YES ☐ NO	
Is there a fiscal impact?	☐ YES ☐ NO	Unsure - further analysis required
What is the length of time needed to implement this change?	8 - 12 Months for promulgation of rules, IT changes and implementation of administrative changes related to training, policy manuals, forms, etc.	
Other comments:	Providing coverage to additional parents will have a positive impact on children.	

Option 4: Cover ALL Children

Cover ALL children living in Iowa, including those who would otherwise be eligible except that they are barred from participation in federal means-tested programs because they are undocumented or are permanent legal residents that have lived in the United States less than five years.

Issues / Concerns

1. Covering undocumented children will be controversial. The number of undocumented children living in Iowa is unknown.
2. Maintaining a stable and adequate funding source to support this initiative.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Amendment to 249A.3 of the Code of Iowa and an authorizing appropriation.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 – Chapter 75.1(249A) of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Adding a code for nonqualified aliens to the Department's eligibility system is estimated to require 30 hours of programming. Related system manual and Easy Help programming changes are also required. Further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES ☐ NO	This population of children is not eligible for federal match so the cost of Medicaid services would be 100% state dollars. Cost comparisons based on current Medicaid members may underestimate the cost due to pent-up demand for medical care needed by this portion of the population that has lacked health coverage and basic preventive care. Using 3-year averages of census data, Iowa's non-citizen child population < 300% Federal Poverty Level is projected to be 10,900 in 2010. **Total State Dollars:** • Covering only the estimated 1,600 children who lack other health insurance - $4.5 - $5 M. • Cover all 10,900 children - $17 - $32 M.

To implement this change....		Comments (list legal cites if applicable)
What is the length of time needed to implement this change?	8 months for promulgation of rules and implementation of administrative changes related to training, policy manuals, forms, etc.	
Other comments:	It is difficult to estimate the number of undocumented children who could potentially qualify. Census data for Illinois indicated there were 30,000 undocumented children in the state. Current enrollment of undocumented children in Illinois' All Kids program is 48,000. Factors that make this estimation difficult may include: • Underreporting of undocumented status to census data officials • Population migration to states that extend coverage to nonqualified aliens • Qualified alien or citizen children being reported as undocumented in order to circumvent more cumbersome citizen/alien status verification requirements	

Option 5: Expand Medicaid for Pregnant Women to 300% of the Federal Poverty Level

Currently both infants and pregnant women are covered under Medicaid if family income does not exceed 200% of Federal Poverty Level. H.F. 2539 expanded Medicaid coverage to infants when family income does not exceed 300% of the Federal Poverty Level but did not equally expand coverage to pregnant women. This will result in infants being Medicaid eligible whose mothers were not eligible for prenatal care, labor and delivery services or postpartum care. In 2006, Iowa Medicaid paid for approximately 42.6% (n=17292) of all Iowa births. It is anticipated that a lower percentage (35%) of higher income women would be uninsured and apply for Medicaid to cover the costs of the pregnancy.

Issues / Concerns

Maintaining a stable and adequate funding source to support this initiative.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Amendment to 249A.3 of the Code of Iowa and an authorizing appropriation.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 – Chapter 75.1(28) of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	The Department's eligibility system would need programming to accommodate eligibility calculations at the higher income level. Further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES	The projection of pregnancies for 2010 for women

To implement this change....		Comments (list legal cites if applicable)
	☐ NO	with family income of 200% - 300% of Federal Poverty Level is 10,792. Assuming that 35% will apply for Medicaid, Medicaid would cover 3,777 additional births. This initiative would increase the income limit for the Presumptive Eligibility for Pregnant Women program and allow more women to obtain prenatal care who may not otherwise qualify for Medicaid. Additionally, some undocumented pregnant women will qualify for emergency medical services for labor and delivery costs that do not qualify under current rules. **Total State Dollars: $6 - $7M**
What is the length of time needed to implement this change?	8 – 12 months for promulgation of rules and implementation of administrative changes related to training, policy manuals, forms, systems, etc.	
Other comments:	If this Option is adopted, consideration should be given to either removing the current pregnant women coverage provisions from the IowaCare waiver or increasing the income limit to allow women to spenddown to 300% if their income is between 300% and 400% Federal Poverty Level.	

Option 6: Define Medicaid & ***hawk-i*** Coverage as Creditable Coverage for Portability into the Individual Market

Under the federal Health Insurance Portability and Accountability Act (HIPAA), Medicaid and ***hawk-i*** are considered creditable coverage for portability into the **employer group** market. This means that enrollment in these programs counts as other coverage for the purpose of pre-existing conditions exclusions of the employer coverage. For example, if the employer plan has a 12-month pre-existing condition exclusion, every month the child was covered under Medicaid or ***hawk-i*** would count towards the 12-month exclusion. If the child had been covered under these programs for more than 12 months, the pre-existing conditions exclusion period would have been met.

However, creditable coverage portability under HIPAA does not apply to the **individual** market. Therefore, even if the child had creditable coverage under Medicaid or ***hawk-i,*** the child would be subject to underwriting and pre-existing conditions exclusions when obtaining coverage in the individual market. This is an issue for families who are self-employed and cannot obtain coverage in an employer group.

Under this Option, Iowa insurance law would be amended to allow creditable coverage under Medicaid and ***hawk-i*** to count towards the pre-existing conditions time limits applied to policies in the individual market.

Issues / Concerns

This Option will be controversial with the Iowa insurance industry.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	The following sections of the Code of Iowa will need to be amended: 514A.3B 514I.2 513C.3(15)
Are amendments to the administrative rules required?	☐ YES ☒ NO	
Are changes to IT systems needed?	☐ YES ☒ NO	
Is there a fiscal impact?	☐ YES ☒ NO	
What is the length of time needed to implement this change?	None - this policy would become effective upon enactment of the legislation.	
Other comments:	This may be controversial with the insurance industry, which raised concerns at the end of the last session of the General Assembly when it was suggested that ***hawk-i*** be considered creditable coverage.	

Application and Eligibility Reviews / Renewals

Option 7: Implement Single Pay Stub Income Verification

Under this strategy, Iowa would revise policy to require only one pay stub as verification of earned income for Medicaid programs for families and children and the ***hawk-i*** program when it is indicative of future income. Current policy specifies that pay stubs from the past 30 days may be used when projecting income, if the income from that time period is a good indicator of future income. When income from the past 30 days is not a good indicator of future income, DHS staff work with the applicant to determine the best indicator of future income.

Other states utilizing this methodology:

State	Process
Illinois	▪ Accepts one pay stub as verification of earned income. ▪ Reduction noted in denials and cancellations. ▪ Improved processing times. ▪ No increase in errors has been experienced.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 -- Chapter--75.57 (9) & 86.2(2) of the Iowa Administrative Code
Are changes to IT systems needed?	☐ YES ☒ NO	
Is there a fiscal impact?	☒ YES ☐ NO	Possibly. Income limits would not be changing but it can be anticipated that more people would become eligible or stay enrolled by simplifying this income verification requirement. Data is not available on how many people this would impact so fiscal impact cannot be estimated. Further analysis needed.
What is the length of time needed to implement this change?	8 months for promulgation of rules and implementation of administrative changes related to training, policy manuals, forms, etc.	

To implement this change....		Comments (list legal cites if applicable)
Other comments:	The Department would not want to proceed with this change if it cannot also be adopted by the other programs under which families may qualify (e.g. Family Investment Program, Childcare & Food Assistance). Requiring only one pay stub for Medicaid but requiring more pay stubs to verify income for other programs will result in confusion for families and possibly lead to more lost coverage. SSI-related Medicaid would still have to follow federal guidelines so this would disalign FMAP-related policies from SSI-related Medicaid policy. Some DHS forms/instructions, pamphlets, manuals, and training materials would need to be revised.	

See Attachment D - Single Pay Stub Income Verification

Option 8: Average 3 Years of Self-Employment Income to Establish Eligibility

Currently, income for self-employed families is based on the most recent years' tax return or business records; whichever is the most accurate projection of future income. Because income of self-employed families may fluctuate from year to year, children may lose coverage one year and become eligible the next. For example, a farmer may have a good crop one year and a poor crop the next. To account for fluctuations in income, this Option is to use a three-year average of income rather than a single year to establish eligibility for self-employed families.

Issues / Concerns

This may be controversial with some taxpayers.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	Legislation is not required because this is a process to verify income, rather than an income policy.
Are amendments to the administrative rules required?	☐ YES ☒ NO	Rules would not be required because this would be an expansion of possible ways to determine ongoing eligibility.
Are changes to IT systems needed?	☐ YES ☒ NO	Reviewing tax returns and determining the correct income to use is a manual process.
Is there a fiscal impact?	☐ YES ☐ NO	Further analysis needed

To implement this change....	Comments (list legal cites if applicable)
What is the length of time needed to implement this change?	60 days. Updating the policy instructions in the Employees' Manual is all that is required.
Other comments:	Requesting 3 years of tax returns may be burdensome for the family to provide. If the current tax return is not indicative of future income, then working with the family is the most beneficial for both the worker and family.

Option 9: Express Lane Eligibility – Consider an Application for Free & Reduced Price Meals as an Application for Medicaid

This approach would allow an application for the National School Lunch Program to be used as a Medicaid application for any child under the age of 19.

Anyone completing the National School Lunch Program application would have their application forwarded to DHS for a determination of Medicaid eligibility unless they mark a box on the application indicating they do not want the application forwarded.

Currently, in Iowa, the National School Lunch Program application asks the parent to "check here" if they do not want the family information shared with the ***hawk-i*** program. Iowa school districts are mandated to provide the ***hawk-i*** program with a list of families who did not object to the sharing of their information. The ***hawk-i*** program mails applications to all families on these lists. In the 2007-2008 school year, 29,643 ***hawk-i*** applications were mailed to families through this effort. The ***hawk-i*** program refers applications to Medicaid when it appears the family income is within the Medicaid income limit. This Option would take the current process one step further by considering the application for the Free & Reduced Priced Meals programs as an application for Medicaid and ***hawk-i.***

Other states utilizing this methodology:

State	Process
Illinois	Chicago school district electronically matched Medicaid and the NSLP (National School Lunch Program) lists, then mail an application. Applications were not returned complete.
Indiana	Match between Medicaid and NSLP lists, then mailed application. Follow up phone calls. Took up to four types of notices before family applied.
Maryland	Match between Medicaid and NSLP lists. School staff provided outreach, mailed application, provided assistance, and follow-up.
Utah	Match between Medicaid and NSLP lists. Screening letter mailed by school. Families that returned the letter were contacted by an outreach worker to assist with application.

Issues / Concerns

1. The number of applications processed by DHS could increase significantly with little results. Additional FTEs would be required to process the applications.
2. The National School Lunch Program application would require revisions to meet federal requirements for Medicaid.
3. Accepting this application would increase the number of applications DHS currently uses.
4. Citizenship & identity verification and social security numbers would have to be requested by DHS staff.
5. Updated technology would be required in order to screen for children who already get Medicaid or ***hawk-i*** so they are not contacted unnecessarily because of this process.
6. This effort may be duplicative of current outreach efforts to families through the National School Lunch Program.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Legislation is needed and an appropriation would be required (see fiscal impact) or to mandate the Department of Education to provide the application to DHS.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 -- Chapter--76 of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Technology upgrades may be needed to allow automatic screening out of current Medicaid/***hawk-i*** eligibles and electronically forwarding of application from schools to DHS.
Is there a fiscal impact?	☒ YES ☐ NO	Technology upgrades. Staffing – outreach workers to follow up to gather complete application information. Further analysis needed.
What is the length of time needed to implement this change?	Minimum 12 months to design the program, promulgate rules, amend contracts, and develop materials to inform the public about the new program.	

To implement this change....		Comments (list legal cites if applicable)
Other comments:	▪ Other states found that outreach or gateway through schools is less successful than through provider gateways, and required extensive follow-up, which places an administrative burden on school personnel or state eligibility staff. ▪ Differences between the Medicaid application and the National School Lunch Program could be a barrier to successful implementation. Confidentiality requirements may also differ. ▪ Other states found that families checked the box to apply for Medicaid when they were already on, causing unnecessary applications. ▪ Requires a 2-step process because Medicaid must verify income and citizenship and identity before approval. Differences between school lunch and Medicaid alien status, income, household, and signature requirements would also need addressed. ▪ Role of school personnel in Medicaid may be limited in future depending on outcome of federal regulations.	

See Attachment E: NSLP Application

Option 10: Express Lane Eligibility – Define Food Assistance and Family Investment Program (FIP) Eligibility as 'Categorical' Eligibility for Medicaid

This approach would specify that when a child under the age of 19 has been determined eligible for Food Assistance or the Family Investment Program, the child would be deemed eligible for Medicaid and automatically enrolled.

Donna Cohen Ross from the Center on Budget and Policy stated that federal legislation is needed to allow states the flexibility to pursue "automatic enrollment options" as well as to remove barriers imposed by the Deficit Reduction Act (DRA) of 2005 in which citizenship and identity verification requirements were mandated for Medicaid. National advocates are going to continue pursuing legislation in this regard.

"Automatic enrollment options" are defined as when a state accepts another program or agency's determination of eligibility for Medicaid eligibility (e.g. Food Assistance, Family Investment Program {FIP}, or National School Lunch Program, {NSLP}). Current federal law does not allow the Medicaid program to accept the income determination of another program to establish Medicaid eligibility.

No states were found that utilize this process.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Federal – Title XIX of the Social Security Act and Chapter 249A of the Code of Iowa
Are amendments to the	☒ YES	441 -- Chapters--76.1 (249A) and 75.11(249A) of

To implement this change....		Comments (list legal cites if applicable)
administrative rules required?	☐ NO	the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Impact would have to be determined after federal and state legislative authority granted.
Is there a fiscal impact?	☒ YES ☐ NO	Unable to estimate at this time. Fiscal impact is dependent upon being granted federal authority. Further analysis needed
What is the length of time needed to implement this change?	Assuming federal and state authority, a minimum of 12 months for promulgation of rules, IT changes and implementation of administrative changes related to training, policy manuals, forms, etc.	
Other comments:	If federal legislation did not accomplish true categorical eligibility/auto enrollment by waiving Medicaid requirements that do not apply to Family Investment and Food Assistance Programs, there would still be a two-step process to gather information (e.g. citizenship verification) or notify households of Medicaid-specific requirements (e.g. cooperation with third party liability, retroactive coverage, etc).	

See Attachment F:. FA/FIP Application

Option 11: Improve Renewal Process

Once children are enrolled, keeping them enrolled is challenging for states. Following are several options designed to improve the renewal process in an effort to reduce the number of children who lose coverage simply because of administrative processes.

Option 11A: Allow More Time to Renew Medicaid Coverage

Currently, the Medicaid renewal form is mailed at the end of the month before the review month. Families are given approximately 10 days (including mailing time) to complete the renewal form and gather all required documentation. If the form is not received in the local DHS office by the due date, a notice of cancellation is issued to the family.

Under this proposal, members would receive the Medicaid annual review form one month earlier than the current practice of mailing the form approximately seven days before its due date. This would allow members a longer period of time to complete and return the review form to the Department. Cerro Gordo County piloted this concept and found that 95 percent of members retained Medicaid eligibility compared to the control group (current practice) with 82 percent retention.

Note: This process would be spread to the Food Assistance and Family Investment Programs as well as Medicaid.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 – Chapter 75.52(4) of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	The Department's eligibility system would need programming to accommodate the longer periods for generating and tracking renewal forms. Further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES ☐ NO	Systems development. Further analysis is needed to establish the extent of effort and the cost associated with the various options.
What is the length of time needed to implement this change?	8 months for implementation of IT and administrative changes related to training, policy manuals, forms, etc.	
Other comments:		

Option 11B: Implement Small-Scale Testing With 'Low-Risk' Families for Renewals

Conduct a small-scale pilot to determine if implementing a passive renewal process for families that have constant income from sources, such as, Social Security Administration, Iowa Workforce Development, Veterans Administration or child support will result in increased retention while limiting the risk of errors. These families are considered 'low risk' for errors because of their stable income sources. If the results of the small pilot are positive, then spread the test to a larger group and analyze the results before making a policy decision to implement this process.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 Chapter 75.52(249A) of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Changes would be dependent on structure and size of pilot. Further analysis is required to establish the extent of effort and the cost.
Is there a fiscal impact?	☒ YES ☐ NO	If results of pilot indicate a permanent policy change should be implemented, then IT systems

To implement this change....		Comments (list legal cites if applicable)
		will most likely need modified to identify the families that are eligible for this review process. Further analysis is required to establish the extent of effort and the cost associated with the various options.
What is the length of time needed to implement this change?	8 – 12 months to design and conduct the pilot and analyze results. Further action is dependent upon results.	
Other comments:		

Option 11C: Implement Telephonic Renewal Processes

There are a number of ways that states can implement renewal processes telephonically. Phone contacts allow questions to be asked and answered by both parties.

- Initiate telephone renewals of eligibility in lieu of requiring completed paper renewal forms. Eligibility staff would initiate a call to families who had not returned their renewal document in an effort to avoid enrollment cancellation.

- Implement an automated renewal telephone system. This model allows an individual to call an Integrated Voice Response (IVR) system, available 24/7 that prompts the caller to respond to questions based on the entry of a Personal Identification Number (PIN) or some other identifying information. If the person requests to speak to someone in person, there is an option to leave a message that will result in a call back or to be transferred to an operator during business hours.

- Rolling renewals allow eligibility workers to conduct a renewal and update information at any point during which they are talking to the individual on the phone for any reason. For example, if the individual calls to report an address change, the worker could initiate a renewal if a renewal is due in the near future.

State	Process
Arkansas	Completes annual reviews by telephone for 30 percent of families who did not return review form.

Issues / Concerns

1. States must have technology and policies to support telephone renewal processes in order to be successful. The purpose of doing telephonic renewals will be defeated if the State does not have access to databases by which the information being reported can be verified or policies that will allow acceptance of self-declaration of the person's income and circumstances. Although the person may renew coverage telephonically, if the State requires the individual to provide follow-up documentation before the renewal process is complete there is still an opportunity for disenrollment if the documentation is not provided.
2. While Federal Medicaid and SCHIP regulations do not require a signature as part of the renewal process, FNS does require a signature for Food Assistance. Telephonic renewals may be of limited value if the family is receiving benefits under both programs but cannot be renewed under both in the same process.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Depending on the approach taken, an appropriation may be required.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441—Chapters 75.52(4) & 86 of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	There would be IT changes associated with implementation of an IVR system and with increased access to data sources to verify eligibility in lieu of requiring documentation. Further analysis is required to establish the extent of effort and the cost associated with the various options.
Is there a fiscal impact?	☐ YES ☐ NO	Unknown. Based on Arkansas' findings, potential of 30 percent retention of those who failed to return the review. However, it cannot be established how many of those individuals would have ultimately reapplied and been added back to the program. The phone renewal most likely resulted in an administrative savings when compared to the cost of processing a new application for these individuals. Further analysis needed,
What is the length of time needed to implement this change?	8 months for promulgation of administrative rules, implementation of IT and administrative changes related to training, policy manuals, forms, etc.	
Other comments:		

Option 11D: Implement Passive Renewals

Families would receive a pre-populated review form based on information known to the Department. The pre-populated information would include names of household members, known income, and health insurance. Members would be asked to review the information on the form. If there were no changes to report, the member would not be required to return the form. If there were changes, the member would be required to complete the form, submit proof of changes, and return the form by the due date.

Issues / Concerns

1. Assuming failure to return the form means that there are no changes in the household is risky for states in the event of an audit.
2. Georgia implemented passive renewals for a short period of time but has gone back to a verification policy due to budget constraints.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	
Are amendments to the administrative rules required?	☒ YES ☐ NO	441—Chapter 75.52(4) of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Changes would be required to the eligibility system to populate the renewal form with known circumstances of household. Further analysis is required to establish the extent of effort and the cost associated with the various options.
Is there a fiscal impact?	☐ YES ☐ NO	Cannot be estimated at this time. Further analysis needed.
What is the length of time needed to implement this change?	8 months for implementation of IT and administrative changes related to training, policy manuals, forms, etc.	
Other comments:	This may be one of the riskier options to implement.	

Administrative Enhancements

Option 12: Increase/Improve Technology

Studies have shown that the primary reason for the denial of applications and the loss of coverage at renewal is that families are unable to produce required verification. These 'administrative' denials result in people losing coverage, not because they are ineligible but because they cannot meet the administrative requirements to prove they qualify. States with the highest success rates in enrollment and retention of coverage for eligible people are those that have utilized technology to access databases to verify critical eligibility factors rather than relying on the family to provide documentation.

Accessing information from other sources to verify a family's circumstances is a critical tool for states to implement ex parte' renewal processes and maintain program integrity. Accessing information available through databases also reduces eligibility processing timeframes, postage, worker time and other administrative costs associated requesting information and processing paper

12A: Electronic Verification of Vital Events (EVVE)

The Deficit Reduction Act of 2005 mandated states to verify the citizenship of all persons applying for or receiving Medicaid and related federal regulation identifies in priority order the documents that are considered valid proof. Original birth certificates are identified as second (next to passports) in the hierarchical order of the most credible documents. Data matches with vital records databases are also acceptable verification.

Iowa currently does an electronic data match for people born in Iowa with birth records in the Bureau of Health Statistics, Iowa Department of Public Health through the birth certification verification (BCV) system. Since implementing the BCV process, Iowa has successfully matched 96 percent of the requests for people claiming Iowa as their birth state. However, obtaining original birth certificates has been problematic for individuals who were born in other states both in terms of cost and the time it takes to obtain the document.

The National Association for Public Health Statistics and Information Systems (NAPHSIS) has developed and implemented an electronic system that allows immediate confirmation of the information on a birth certificate presented by an applicant to a government office anywhere in the nation, regardless of the date or place of issuance. Authorized State agency users, via a single interface, can generate an electronic query to any participating vital records jurisdiction throughout the country to verify the contents of a paper birth certificate or to request an electronic certification in lieu of the paper birth certificate. An electronic response from the participating vital records jurisdiction either verifies or denies the match with official state or jurisdiction records. It will also flag

positive responses where the person matched is now deceased. As designed, queries can be generated and matched against 250 million birth records in jurisdiction vital record databases nationwide. The EVVE system is also capable of supporting the electronic verification and/or certification of death records.

The EVVE system would allow DHS to match birth records nationally to verify citizenship of individuals born in other states. Twelve states, including Iowa, are currently on-line with EVVE for various purposes. In some cases, EVVE is being piloted with a state's Department of Motor Vehicles offices to query participating vital records offices to verify birth certificates presented by a person applying for a driver's license or ID card.

Other states utilizing this methodology:

State	Process
Michigan	Database allows data matching of Michigan births 70 percent of the time. Transformation grant approved to revise intake worker interface.
South Dakota	Currently being piloted by the SD Medicaid office. In addition to using EVVE, they are utilizing a product by Systems Made Simple, Inc. called the EVVE-ul. The EVVE-ul provides a secure internet-based front end for EVVE users to enter in birth record query data and display the EVVE response to the user.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Funds to implement EVVE would need appropriated.
Are amendments to the administrative rules required?	☐ YES ☒ NO	
Are changes to IT systems needed?	☒ YES ☐ NO	
Is there a fiscal impact?	☒ YES ☐ NO	There is a per inquiry charge to access the system. Minnesota has had 136 searches and South Dakota has had 360. Assuming Iowa has 300 – 500 per month: **Total State Dollars: $3,000 - $5,000**
What is the length of time needed to implement this change?	60 days to implement access to the system, update policy manuals and train field staff on use of EVVE.	

To implement this change....		Comments (list legal cites if applicable)
Other comments:	Match rates with EVVE will vary depending on integrity of data maintained by each state's own vital records office, and states are all at varying points in bringing their birth records online.	

See Attachment G: EVVE

12B: Enhanced WORK NUMBER

More and more employers are utilizing outside vendors to respond to the increased number of requests by banks, government agencies, and others for employment verification of their employees. Some employers rely exclusively on these services and refuse to provide information directly. The WORK NUMBER is the most widely used of these vendors.

Currently, eligibility staff uses The WORK NUMBER's fax service to submit requests to verify employment. There is no charge for this service but responses take 2 – 3 days from the date of the request and provide only limited information.

The WORK NUMBER also offers an expanded on-line service where the worker enters a name and social security number and immediately receives a summary report listing all employers for as long as six years in the past. The summary report indicates whether the employment for each named employer is "active" or "inactive". For this service, the state pays $1.50 per inquiry. For active employment, the worker can request a detailed report showing hours worked per pay period; pay rate; total earnings; and start and end dates. This report costs $6. According to the company, the database contains information for approximately 28% of the working population.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☐ YES ☒ NO	
Are amendments to the administrative rules required?	☐ YES ☒ NO	
Are changes to IT systems needed?	☐ YES ☒ NO	
Is there a fiscal impact?	☒ YES ☐ NO	Further analysis is needed to establish the cost and the return on investment. The enhanced access may result in administrative savings in terms of time, postage and application processing. There may also be some program savings resulting from more accurate/complete

To implement this change....		Comments (list legal cites if applicable)
		information being used to determine eligibility.
What is the length of time needed to implement this change?	60 days to implement access to the system, update policy manuals and train field staff on use of the enhanced WORK NUMBER.	
Other comments:	Having access to up to 6 years of employment data will be helpful in efforts to maintain program integrity.	

See Attachment H: TALX

12C: Data Brokering Systems - eFIND

eFIND is a timesaving computer application that allows government agencies to verify income and assets for assistance programs. **eFIND** software is free to government agencies but there are costs to adapt it to a state's system. It provides eligibility workers with intelligent, filtered, well-organized information for eligibility decision-making for a variety of public assistance programs. The system identifies relevant information from 18 different federal / local data sources and assists the eligibility worker in making an eligibility determination.

Utah	Workers use **eFIND** to make one 5 – 15 second search and obtain information from 18 different federal /local data sources. Utah spent $2.1 million (total dollars) building their system but estimates their savings in staff time during the first year alone exceeded the cost of the system.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Funds to implement **eFIND** would need appropriated.
Are amendments to the administrative rules required?	☒ YES ☐ NO	IAC 441 – Chapter 75
Are changes to IT systems needed?	☒ YES ☐ NO	
Is there a fiscal impact?	☒ YES ☐ NO	Although **eFIND** software is free to government agencies, there would be a cost to install it in the Department's systems. Further analysis is needed to establish the extent of effort and the cost.

To implement this change....		Comments (list legal cites if applicable)
What is the length of time needed to implement this change?	Systems changes - Unknown at this time. An analysis of the system requirements and effort needed to implement would have to be conducted. 6 months for amendments to administrative rules.	
Other comments:	None.	

12D: Customer Portals

Under this strategy, DHS would implement technology enhancements to its eligibility computer system that would allow customers to electronically:

- Check on the status of their application,
- Check their benefits,
- Report changes, and
- Have information verified without being contacted

Other states utilizing this methodology:

State	Process
Arizona	Web-based application system allows screening for multiple programs. Applications are submitted on-line with electronic signature. Case records are electronic. Enhancements will be to complete reviews on-line and make changes. Developing a web-based health information exchange.
Michigan	Electronic application can be completed in 25 minutes with system prompts for missing information and provides immediate potential eligibility feedback to applicant.
Pennsylvania	COMPASS system allows application and renewal on-line for multiple programs in multiple languages. "Smart system" asks only relevant questions.
Wisconsin	On-line application includes a screening tool to easily see potential eligibility for several programs before submitting an application. Members can check benefits and report changes on-line.

To implement this change....		Comments (list legal cites if applicable)
Is legislation required?	☒ YES ☐ NO	Funds to implement would need appropriated.
Are amendments to the administrative rules required?	☒ YES ☐ NO	441 – Chapters 75 & 76 of the Iowa Administrative Code
Are changes to IT systems needed?	☒ YES ☐ NO	Further analysis is required to establish the extent of effort and the cost.

To implement this change....		Comments (list legal cites if applicable)
Is there a fiscal impact?	☒ YES ☐ NO	Anticipated fiscal impact could be significant, primarily due to initial costs of implementing the needed technology. Further analysis is needed to establish the extent of effort and the cost associated with the various options.
What is the length of time needed to implement this change?	The migration of the eligibility system off the mainframe is expected to take 2-3 years. Until that is complete, DHS will not have the functionality to proceed with many of these enhancements (e.g. adding system functionality for online report of changes or check benefits features, "connectors" between system to allow DHS to data match with other agencies) without significant expense and additional FTEs due to the complexity of managing the security issues while the eligibility system is on the mainframe. The timeline, staffing, and budget for the project migrating these off the mainframe or completing related enhancements would require further research to establish the extent of effort and the cost. OASIS phase 2 has already begun and will allow online application to interface with applications from other sources (e.g. WIC, well child care, assistance for pregnant women). When an applicant for one program indicates an interest in a separate program, a system interface available in 2009 will allow the sharing of enough information so that the other agency can follow up by contacting the applicant.	
Other comments:	Safeguards must be taken to protect identifying information and ensure matching the right individual when using data matches for enrollment/verification. Memorandums of Understanding (MOUs) would have to be established with any agency with which data sharing would occur.	

See Attachment I: Technology

Additional Discussion Points

Several ideas were proposed at the Health Care Summit that merit further consideration but, at this point in time, are not being included as options. Each is discussed below:

- Use one application form for children's healthcare in Iowa.

  Response: Currently, although the Medicaid and ***hawk-i*** programs are administered as separate programs with separate application and eligibility requirements, there is no 'wrong door' when applying. If a family applies for ***hawk-i*** and the children qualify for Medicaid; or they apply for Medicaid and qualify for ***hawk-i***, there are processes in place to refer the application to the appropriate program. Under the current program structures, to have a single application form may be confusing to families.

- Consider mandating schools to provide DHS with the names of all uninsured children for outreach and enrollment purposes, not just those on the Free & Reduced Price Meals program.

  Response: The Department has approached the Department of Education (DED) with this proposal in the past. DED expressed concerns about sufficient resources and local control issues. Unless mandated and adequate resources are provided, it is unlikely that this can be accomplished.

- Create a children's health system, combining presumptive eligibility to encompass ***hawk-i*** and Medicaid.

  Response: Further discussion will have to occur to better understand the goals of this suggestion before the Department can take a position.

- Consider renaming / re-branding Medicaid and ***hawk-i*** or implement other strategies to reduce stigma.

  Response: Some states have adopted the approach of having one children's health insurance program. For example, Illinois has implemented the All Kids Program. States that have done this successfully are either Medicaid expansion states or states with a separate SCHIP program that utilizes the Medicaid provider network and provider reimbursement structure so that regardless of whether the child is on Medicaid or SCHIP, children go to the same providers who file claims and get reimbursed in the same manner. To have one program name for two programs with separate structures and provider reimbursement schedules as the Medicaid and ***hawk-i*** programs are currently designed will create much confusion for both the public and provider communities. States that have attempted to disguise their Medicaid program by calling it something else have reported that families and providers quickly learn the difference. For example, Connecticut implemented HUSKY A, which was their Medicaid program, HUSKY B, which was their SCHIP program, and HUSKY C, which was

an additional benefit package for disabled children. State officials report that even though Medicaid was called HUSKY A, the 'stigma' of receiving a program that was perceived as welfare remained and families requested that they be put on HUSKY B.

To create one program successfully will require significant analysis, thoughtful consideration, and marketing.

- Link presumptive eligibility with other strategies that reach out to families. For example if a child is on the Free & Reduced Price Meals program, connect them with a presumptive eligibility provider.

  Response: This suggestion can most likely be accomplished by educating entities that come in contact with families and children about presumptive eligibility for children if that Option is adopted.

- Create 'listening posts' to go out into the communities around the state and ask families what they need. How do the programs serve them? What would help? Formulize a process for identifying barriers to enrollment from stakeholder groups. Incorporate as a requirement of current grassroots outreach contracts.

  Response: Identifying barriers to enrollment is a component of the grass roots outreach contract between the Department of Human Services and the Department of Public Health. Outreach coordinators currently have the ability to create listening posts and gather data within their communities. One barrier to accomplish this, however, may be the limited funding that is available at a local level.

- Consider utilizing current EPSDT care coordinator assistors in the renewal process for Medicaid.

  Response: This may be a viable suggestion but will take further analysis before the Department can take a position. The Department currently contracts with the Department of Public Health for the EPSDT services. Expanding that service to include outreach to assist families with enrollment is beyond the current contract scope and will most likely have a fiscal impact. Although the outreach coordinators who are also contracted through IDPH primarily focus on initial enrollments, some do help families with renewals. Ensuring that a duplication of effort is not created will be important in maximizing available resources.

- Mandate coverage for kids.

  Response: To date only one state, Massachusetts, has mandated coverage for children. Mandating coverage may be very controversial with some and its success will be dependent upon the availability of affordable health care

coverage. It is not clear how mandated coverage will be enforced. Much analysis will have to occur before this suggestion could be implemented.

- Implement continuous eligibility for adults.

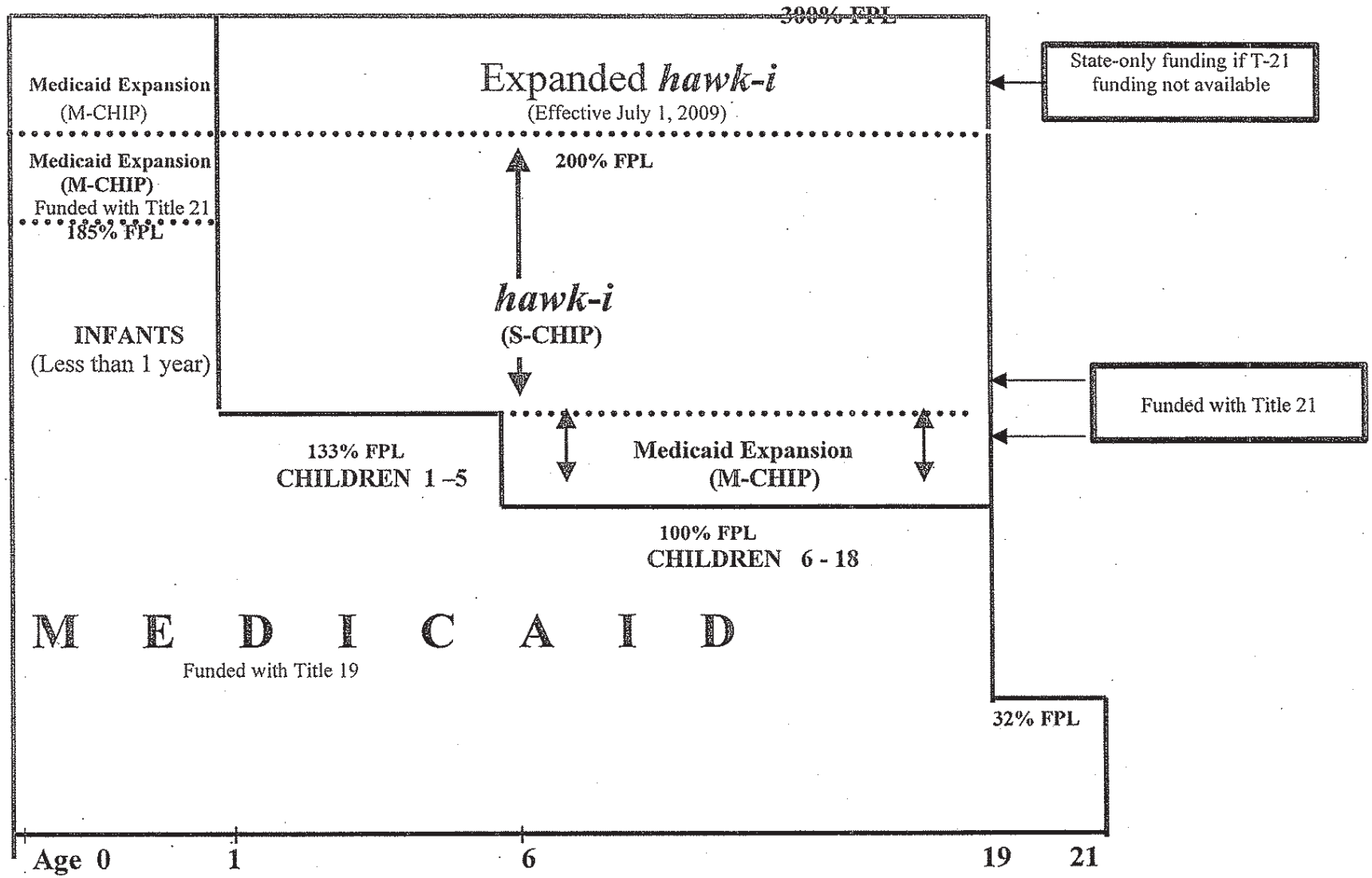
  Response: Continuous eligibility for adults is not currently an option under Federal law. Doing so would require 100% state funds. Rather than implementing continuous eligibility for adults who qualify under current Medicaid guidelines, the Department would rather draw down additional federal funds to expand coverage to more adults who currently don't qualify for Medicaid.

  - Some studies suggest that parents of uninsured children often remain uninsured, choosing instead to keep the money they would spend on their own health insurance to pay for the health care of their children. But, once their children obtain coverage, even through publicly funded programs, parents are more likely to obtain health insurance for themselves. It was suggested that a mandate for children to have health insurance coverage might result in more parents becoming insured.

Attachment A: Iowa's Healthcare Programs for Non-Disabled Children

Iowa's Health Care Programs for Non-Disabled Children

Attachment A



Attachment B: Agenda - SCHIP & Medicaid Summit: Maximizing Opportunities for Children in Iowa

Attachment B

CHILD & FAMILY POLICY CENTER

SCHIP and Medicaid Summit: Maximizing Opportunities for Children in Iowa

Thursday, September 11, 2009
1:00 p.m. – 4:30 p.m.

1:00 p.m.	**Welcome** Ann Wiebers, Iowa DHS **Why We're Here** Particularly as ***hawk-i*** is extended to 300% FPL, it is important that its benefits be aligned, to the extent feasible, with private health coverage while still remaining affordable to families. This session will introduce the topics for that day that will address the important issues of coordinating with private sector coverage. **Presenter:** Charlie Bruner
1:30 p.m.	**Developing a Cost-sharing and Copayment Structure that Works for Iowa's Families** As it expands to 300% of poverty for its ***hawk-i*** program, Iowa also needs to review its cost-sharing policies, particularly at the higher income levels. States vary widely on the cost-sharing, co-payments, and maximum out-of-pocket expenses they impose at higher income levels, but all do something to increase parent financial responsibility. This session will review different state approaches in relation to Iowa's current structure, and offer information on the trade-offs involved in different approaches. **Presenters:** Anita Smith, DHS Iowa Donna Cohen Ross, Center on Budget and Policy Priorities Liz Arjun, Georgetown Center for Children and Families
2:30 p.m.	**Break**
2:45 p.m.	**Premium Assistance: Providing Coverage Options and Minimizing "Crowd Out": An Introduction** As eligibility for public programs is expanded to higher income levels, parents often have choices to make between public coverage and coverage available through their employers which may involve cost-sharing that is prohibitive to families participation. To assist families to afford the cost-sharing requirements for their employer-based coverage and to allay some concerns about "crowd out" concerns, Iowa is considering expanding its currently existing "premium assistance" program. This session provides an introduction to Iowa's current

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	premium assistance program, how it works and what the opportunities and trade-offs are in expanding this program. **Presenters:** Anita Smith, Iowa DHS Cindy Mann, Georgetown Center for Children and Families
4:00 p.m.	**Q&A** – Carrie Fitzgerald, moderator (all presenters to answer questions)
4:30 p.m.	**Adjourn**

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CHILD & FAMILY POLICY CENTER

SCHIP and Medicaid Summit: Maximizing Opportunities for Children in Iowa

Friday, September 12, 2008
9:00 a.m. – 3:30 p.m.

The purpose of this daylong summit is to draw upon expertise from Iowa and from across the country to examine and discuss best practices available to Iowa in our efforts to increase the number of children who enroll and retain coverage in hawk-i and Medicaid.

8:30 a.m.	Continental Breakfast and Coffee
9:00 a.m.	**Welcome, Celebrating our Success, and Looking Forward to What's Next for Children's Coverage in Iowa** Ann Wiebers, Division Administrator, DHS Carrie Fitzgerald, Iowa Child and Family Policy Center
9:15 a.m.	**Iowa Context and National Examples of What Might be Possible in Iowa's Efforts to Move Forward** This session will describe Iowa's opportunity to lead the nation in covering all children through the landmark legislation enacted in 2008, point to the need for effective implementation to achieve its goal and will outline the issues that need to be addressed to ensure coverage of all eligible children. An overview of Iowa's Medicaid and ***hawk-i*** programs will be presented along with a sampling of possible strategies used in other states to reach eligible but unenrolled children. **Presenters:** Anita Smith, Iowa DHS Cindy Mann, Georgetown Center for Children and Families
10:00 a.m.	**Getting Children Enrolled: Streamlined Enrollment/Presumptive Eligibility** This session will describe strategies that are or have been utilized in other states to increase enrollment through a more simplified and streamlined enrollment process while ensuring compliance with federal law. This session will also present an overview of how the enrollment process in Iowa currently works and where changes in policy and regulation might result increasing the number of children who successfully enroll. **Presenters:** Anita Smith, Iowa DHS Cindy Mann, Georgetown Center for Children and Families Donna Cohen Ross, Center on Budget and Policy Priorities
11:00 a.m.	**Break**

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11:15 a.m.	**Keeping Children Enrolled: Strategies to Improve Program Retention** This session will describe the importance of developing a seamless renewal process that avoids children losing coverage as a part of the reapplication process. It will describe the gains in overall enrollment that Iowa may be able to achieve based on examples from other states, with a specific focus on one state, Louisiana. It will also provide an overview of how the renewal process in Iowa currently works and where changes in policy and regulation might result in improving the number of children who stay enrolled. **Presenters:** Anita Smith, Iowa DHS Cindy Mann, Georgetown Center for Children and Families Ruth Kennedy, Director Louisiana SCHIP (LaCHIP)
12:15 p.m.	**Lunch**
1:00 p.m.	**Other Opportunities to Increase the Number of Children who Get and Stay Enrolled** Once we identify ways that Iowa can improve the enrollment and retention for our health care programs, what else can we do to reach eligible children? This session will look at other strategies Iowa might consider to increase enrollment and retention including outreach, application assistance to families and improved coordination. **Presenters:** Tricia Brooks & Liz Arjun, Georgetown Center for Children and Families
1:45 p.m.	**Breakout Sessions** During this session, summit participants will be asked to divide into three groups based on the topics discussed during the day – streamlined enrollment and presumptive eligibility, expedited renewal, and other options to increase enrollment/retention in Iowa's *hawk-i* and Medicaid programs. State and national staff will facilitate these discussions.
2:45 p.m.	**Breakout Reports** Representatives from the groups will be asked to summarize their discussion, highlight the strategies they think should be pursued and identify key areas where more research is needed. A panel of state and national experts will be available to answer questions that emerge from the small groups. **Facilitator:** Carrie Fitzgerald, Iowa Child and Family Policy Center
3:15 p.m.	**Closing Comments and Next Steps** Ann Wiebers, DHS

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Attachment C: Gateway Model

Attachment C: Gateway Model

Proposal: Raise awareness of recent enhancements to DHS' online application and encourage partners (e.g. hospitals, doctors, WIC, visiting nurse services, school and child care personnel, Head Start, and other community-based outreach workers) using these existing technologies to assist uninsured low-income children in applying for Medicaid/hawk-i.

Description: System upgrades (OASIS) currently nearing completion and expected for rollout in the fall of 2008 will make an application available online which customers can use to apply for multiple benefit programs including Medicaid. This application can be submitted 24/7 with a single electronic signature. These technologies can easily be used by providers, community-based outreach workers, and others who already come into regular contact with uninsured low-income children. Promoting application assistance through these provider gateways will help customers, save time for DHS staff, and ensure medical providers receive prompt payment for services.

Legal References: NA

Experience of Other States:

Michigan: Online application provides access to isolated populations by allowing families to apply from home. Outreach workers can assist those who don't have internet access – customer can call outreach workers who relay their information on electronic application. Accessibility of system attracts new partners (e.g. hospitals, doctors, community outreach workers, schools). (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Pennsylvania: Helpline staff takes information by phone, then enters the data and submits application online through state's web-based system. Online applications had much higher rate of being complete and ready to process than those when customer was mailed a paper application. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Illinois: Found that outreach is more successful when done by providers/doctors/clinics and is less successful through schools. Outreach includes community groups who are paid $50 for each enrolled applicant they initiate. (source: 5/08 NASHP conference presentation)

Hawaii: Outreach workers assisted uninsured ER or hospital patients in completing Medicaid/SCHIP applications and receptionist fax the signed & completed appl to DHS the same day. Outreach worker also checked daily list to identify uninsured hospital patients and automatically provided newborn delivery verification to DHS automatically. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Massachusetts: "Virtual Gateway" provider-assisted enrollment tools allows hospitals and community providers to help people apply for coverage online via a common intake application with the needed data elements for 18 programs (source: 5/07 e-health snapshot article)

North Carolina: Hospital ER assisted parent of any uninsured child in completing "bare bones" Medicaid application before hospital discharge and forwarded to outreach worker stationed at

hospital; outreach worker followed up by calling family to complete rest of application before sending on to Medicaid agency for processing. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Oklahoma: Outreach and awareness campaign to enroll pregnant women, particularly Hispanic women, by educating and providing technical assistance to medical professionals. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

California, Utah, Indiana, & Maryland : Have used school personnel to assist in outreach through NSLP gateway. See Streamlined Enrollment Proposal #5 on School Lunch Program for more information about those states.

Pros and Cons:

Pros:

- Customers consistently report that 24/7 online system access removes a significant barrier to enrollment. Online access destigmatizes Medicaid benefits and does not require parents to miss work to complete the eligibility determination process.
- Can use provider and outreach networks already in place to provide this application assistance.
- Highly accessible web-based system is easy to use from any computer with internet access.
- Because online applications have a higher rate of being complete and ready to process, outreach workers may save time or devote their efforts more to following up with the customer about providing needed verifications.
- Populations that are traditionally disproportionately underinsured may benefit most from provider or outreach worker assisted applications because they will be identified by existing community-based outreach and advocacy efforts. For instance, census data indicates that low income Hispanic children have the highest uninsured rate. (source: Commonwealth Fund scorecard 5/08, www.statehealthfacts.org)
- Customers without home internet access can still benefit from these technologies with application assistance offered at medical clinics, schools, or by outreach workers who already visit customers in their homes.
- Avoids delays in transmitting application to DHS that may exist in other streamlined enrollment models such as using NSLP application to initiate Medicaid process.
- Will not require any interagency or confidentiality agreements with DHS. Existing agreements between customer and provider/outreach personnel likely would be sufficient.
- Pay-for-performance outreach models may provide needed incentive to finding and enrolling hard to reach populations.
- Could offer provider incentives that are not direct pay-for-performance e.g. awards and public recognition.
- If further DHS online system enhancements (e.g. online customer benefit check or change reporting, electronic health file) become available in the future, they also would be useful to health providers and outreach workers.
- This is a "one door" approach that allows families to enroll their children at multiple sites by encouraging them to enroll wherever they touch the system.

- Other states have reported that outreach is generally most effective when it reaches families at the point where they are accessing health care services and are thus motivated to complete the eligibility determination process.

Cons:

- If pay-for-performance outreach model is used this would require new funding and may be a disincentive to current outreach providers continuing to provide application assistance voluntarily.
- Providers that do not currently assist customers in accessing insurance may experience increased administrative burden.
- Significant follow-up may still be needed by existing community-based providers and outreach workers to ensure customers provide required verifications needed for the completion of the Medicaid eligibility determination.

Administrative Issues: We don't anticipate any system changes. Workers would continue to gather needed verification and enter data into the computer system for an eligibility determination.

There may be costs and time associated with the following:

- Pamphlets and other outreach materials
- Training (to providers and community-based outreach workers)

Fiscal Impact: Cost to provide education/outreach to raise awareness and promote use of systems among partners in the provider community.

Pay-for-performance model would have budget impact.

Attachment D: Single Pay Stub Income Verification

Attachment D: Single Pay Stub Income Verification

Proposal: To allow one pay stub as verification of earned income for FMAP-related programs if it is indicative of future income.

Description: Currently, income is counted prospectively and we generally request the past 30 days of income. However, we can use a different period of time and work with the members in order to correctly anticipate future income. (Self employed individuals use tax returns or their books if they don't file taxes.)

Legal References: Iowa Administrative Code 441—75.1(14), 75.57(249A), and 75.58(249A)

Experience of Other States:

Illinois: An advocacy policy work group promoted either dropping income verification requirements or reducing verification to one pay stub. The state implemented verification of one pay stub and

- Experienced a reduction in application denials
- Experienced a reduction in renewal cancellations
- Improved application processing time
- Did not increase errors

Refer also to separate handout for information about self-declaration experiences in several other states.

Pros and Cons:

Pros:

- Reduces verification required of working families
- May reduce requests for more information
- May reduce the number of days needed to process applications/reviews
- May reduce postage and paper expenses
- Easier for both applicants and members
- Easier for workers
- Less error-prone methodology than self-declaration of income
- Less cumbersome for workers than self-declaration models which still require verification methods e.g. data matching, audits, case sampling
- Self-declaration models in some states limited to presumptive eligibility
- Less complex than raising income limits or changing from net to gross limits while eliminating deductions
- No interagency agreement needed

Cons:

- One pay stub may not correctly reflect prospective income so more error-prone
- FIP and FAP use past 30 days of income so different requirements may be confusing for families and error-prone for workers
- No reduction in verification requirements for unearned income

Administrative Issues: We don't anticipate any system changes. Workers would continue to gather income information and enter the data into the computer system. BCW2s (income screen) would still have to be entered.

There will be costs and time associated with the following:

- Manual
- Rules
- Forms
- Pamphlets
- Training
- State Plan Amendment

Fiscal Impact: No known fiscal impact.

Denials for FMAP-related for January 2008 through June 2008 are:
(not known how many of these were specifically due to missing pay verification)

	No info	Over income
Jan	820	0
Feb	836	0
Mar	659	0
Apr	692	1
May	640	1
Jun	610	2

As Medicaid enrollment increases, caseload growth may impact the need for field staff.

Attachment E: NSLP Application

Attachment E: NSLP Application

Proposal: To allow the National School Lunch Program (NSLP) application to be used as a Medicaid application for any child under the age of 18.

Description: The NSLP application will have to be revised so that it can also be used as an application for Medicaid. Anyone completing the application for a child under the age of 18 will have their application forwarded to DHS for a determination of Medicaid eligibility unless they mark a box on the application indicating they do not want Medicaid. However, due to federal mandates, before children can be approved, they will have to provide verification of all Medicaid requirements including income and citizenship/identity.

Legal References: Iowa Administrative Code 441—76.1(249A) Application, 441—75.11(249A)
Rules will have to be updated to allow this.

Experience of Other States:
California: Revised NSLP application is also used as a presumptive Medicaid application. Children receive temporary presumptive Medicaid while state collects additional information for a full Medicaid determination. The date of appl for full Medicaid is the date the NSLP appl is received by the Medicaid agency. This program is optional for school districts and not used statewide; optional due to schools incur unfunded costs. Key lessons learned are

1) many families are confused and apply for Medicaid when already receiving, need technology to weed out duplicate applications to avoid labor intensive manual screening,
2) due to confidentiality requirements of schools, Medicaid was not able to add all their questions to the application so must do 2nd step to request Medicaid information – results in 85% dropoff rate (only 15% of PE go on to full Medicaid),
3) dropoff rate may also be due to primary interest family has in completing PE appl is getting on free school lunch & less motivated to complete full Medicaid verification process than someone at doc/hospital whose primary purpose is health concerns/insurance,
4) requires intensive follow-up by school outreach staff to help family complete full Medicaid application/verification process. (source – expresslaneinfo.org and conference call 8/08 with California staff)

Illinois: An outreach pilot in Chicago school district involved electronically matching Medicaid and NSLP lists, then mailing materials and providing application assistance for Medicaid/SCHIP. Initially found 80% of applications submitted were incomplete. Subsequent outreach required 3-4 contacts to get complete information and required documentation. (source expresslaneinfo.org fact sheet) They noted at 5/21/08 NASHP conference that outreach is more successful when done by providers/doctors/clinics and

is less successful through schools. Other outreach includes community groups who are paid $50 for each enrolled applicant they initiate.

Indiana: Matches between Medicaid and school lunch lists are followed by mailing of materials and follow up contacts by phone or mail to assist families. It took up to 4 types of notices before the family applied for health benefits and that the main notice prompting them to apply was from the school lunch data match. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Utah: Matches between Medicaid and school lunch lists are followed by sending screening letter through school lunch and families returning letters are contacted by outreach worker to assist with Med application. Revised and simplified wording on school lunch application was an important piece of facilitating this link. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Maryland - school enrollment & Medicaid lists were matched to identify uninsured kids. School health staff then provided application assistance as well as follow-up & outreach contacts (e.g. phone & home visits). (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)

Pros and Cons:

Pros:

- May increase Medicaid enrollment
- Reaches eligible uninsured children who are of school age and apply for free/reduced lunches
- Income limit for free lunches is 130% FPL and FMAP-related Medicaid is 133% FPL
- Income limit for reduced lunches is 200% which is higher than FMAP-related programs' 133% but matches hawk-i
- Builds upon current targeted outreach to NSLP applicants already done by hawk-i staff
- Could be augmented by "help line" support or outreach to ensure families follow up to provide verification.
- Model well developed in California and online "school lunch toolbox" kit available as an online resource to build program

Cons:

- Requires two-step process because must verify citizenship and identity, income, etc. before approval
- Even if a second application is not required, postage/paper not saved because must mail supplemental forms and verification requests to family
- Extensive differences between Medicaid and NSLP requirements prevent true auto enrollment. These differences include: Medicaid's citizenship verification, requirements that school officials approve NSLP application even when self

declared income is known to be inaccurate, NSLP only requires SS # of person completing form, school officials can complete NSLP for a family who does not apply, may be different signature requirements, different household compositions including alien eligibility, different dates for updating FPL, 1 year certification with carryover into next school year for NSLP.

- NSLP application would need to be updated to include federal requirements for Medicaid. Requires USDA approval. Would increase size of NSLP application for customers if Medicaid questions were added.
- Does not reach eligible uninsured children age 0-5 unless they have school age siblings
- Even with clear "opt out" statement, some eligible families may be deterred from applying for NSLP for reasons such as undocumented aliens with immigration concerns being afraid to apply for children who are eligible for NSLP
- Requires strong technological supports to work effectively. Requires funding and technological expertise to implement. Technology needs include: 1) method to automatically weed out duplicate applications, 2) electronic means of forwarding application from school to DHS, 3) ideally full electronic data matching between school and DHS and hawk-i systems &/or online applications in use by both systems
- May extend application processing time if delay in forwarding Medicaid application from school to DHS
- Requires interagency agreement. Confidentiality requirements may differ.
- Other states have found low rates of enrollment into full Medicaid unless extensive follow up outreach is conducted. Outreach without additional funding for personnel would cause an administrative burden on either school personnel or state eligibility staff.
- If pay-for-performance outreach model is used this would require new funding and would be a disincentive to current outreach providers continuing to provide application assistance voluntarily.
- Role of school personnel in Medicaid may be limited in future depending on outcome of federal regulations (rule passed at federal level but moratorium on this into 2009)
- If current targeted outreach process to NSLP households is already effectively enrolling kids, may not be cost effective to move to next level of auto enrollment

Administrative Issues: There may be significant system issues as other states' experiences indicate strong technology supports are key to weeding out applications of children already receiving Medicaid/hawk-i. Without this technology, worker time will be wasted manually culling these out or doing outreach to kids who are already enrolled. Because federal law forbids child health programs from relying on the final income determinations of other programs and because of Medicaid's citizenship verification requirements, workers will still have to request all verifications and determine eligibility.

There will be costs and time associated with the following:

- Manual
- Rules

- Forms
- Pamphlets
- Training
- State Plan Amendment
- MOU

Fiscal Impact: Nationally, 71% of all eligible uninsured kids can be found in NSLP/WIC/FA. In 2007, hawk-i did outreach on 29,643 families matched through NSLP, but raw number of children is unknown. Also not known how many of these were already on Medicaid or ***hawk-i***. The NSLP match list comes to DHS between Oct 1-Dec 24 each year. Beginning 1/09, will be able to cull out those kids who are already on hawk-i but will still have no way to determine which kids already get Medicaid. We also do not have data available showing how many of the eligible uninsured kids found through NSLP matching already get on Medicaid or ***hawk-i*** through our current targeted outreach. If the current targeted outreach already enrolls many of the kids found through NSLP then the fiscal impact will be small because this model will not be effective in enrolling many additional kids.

The need for additional field staff would depend on how effective this model is in making more children eligible. Any additional "outreach" required of field staff (to follow up in making sure families complete the verification process) would create need for more staff although may not substantially increase numbers of enrolled children.

Even if raw numbers of eligible uninsured children can be determined, we would still have to consider the numbers that would not become Medicaid eligible due to failure to verify income or citizenship/identity.

Pay-for-performance to outreach providers would have a budget impact.

Attachment F: FA/FIP Application

HEALTH CARE REFORM INITIATIVE -- ATTACHMENT F
Streamlined Enrollment Proposal #2
FA/FIP Categorical Eligibility

Proposal: To allow categorical Medicaid eligibility to children under the age of 18 who have been determined eligible for food assistance (FA) or FIP.

Description: When a child under the age of 18 has been determined eligible for FA or FIP, that determination of eligibility will be accepted and any child under the age of 18 will be eligible for Medicaid. However, due to federal mandates, before children can be added, they will have to provide verification of citizenship and identity.

Legal References: Iowa Administrative Code 441—76.1(249A) Application, 441—75.11(249A)
Rules will have to be updated to allow this.

Experience of Other States: Have not found any other states doing this

See email from CMS which indicates this option cannot be implemented due to federal regulations on single state agency & delegation of authority

Pros and Cons:
Pros:
- Increases Medicaid enrollment
- Reaches eligible uninsured children even if not enrolled in school or preschool
- A Medicaid application will not have to be completed
- Since FA and FIP are a part of the Department, a new data system is not required
- FA application is already online
- No interagency agreement is needed
- Avoids duplication of work for families and for staff
- Same income projection methodology
- Income limit for FA is 130% FPL and FMAP-related Medicaid is 133% FPL
- Income limit for FIP matches the FMAP program which is way under 133% FPL
- Same confidentiality requirements

Cons:
- Appears federal legislation would be required to allow this option (source: fact sheet on Children's Express Lane to Health Coverage Act of 2007 S. 1213)
- Requires two-step process because must verify citizenship and identity before approval
- Different programs' requirements (e.g. household composition, alien eligibility, income) could mean a child is not actually eligible for Medicaid
- FA applications would need to be updated to include federal requirements for Medicaid

- FA application would increase in size for customers if Medicaid questions were added
- Letters would have to be sent to members after approval to ask about retro eligibility
- Does not reach eligible uninsured children who have not applied for another DHS program
- Implications of enrolling people in Medicaid who have not affirmatively applied (e.g. Medicaid requirements to repay overpayments and cooperate with third parties)
- If current targeted outreach process to FA households is already effectively enrolling kids, may not be cost effective to move to next level of auto enrollment. (Note - see data below on number of children who could potentially be enrolled into Medicaid from FIP/FA)

Administrative Issues: We don't anticipate any system issues. Workers would have to request citizenship and identity before approving Medicaid. BCW2s would still have to be entered. Workers would still have to enter separate Medicaid approval in system.

Fiscal Impact: From IME as of 9/5/08: There were 4,325 children on FA who were not on Medicaid; 181 of these kids could be identified from their notice reason codes as having been denied/canceled due to lack of citizenship proof for Medicaid. Similarly, there were 629 children on FIP who were not on Medicaid; 202 of these children were denied/canceled due to lack of required citizenship proof.

A data match is already done between FA and Medicaid for targeted outreach, but related applications are not currently tracked so we do not have data available to show how many of these kids already get on Medicaid by responding to this targeted outreach.

Even if raw numbers of eligible uninsured children can be determined, we would still have to consider the numbers that would not become Medicaid eligible due to failure to verify income or citizenship/identity.

Due to higher caseloads, this may impact the need for field staff.

Attachment G: EVVE

Attachment G: EVVE

Proposal: Utilize the Electronic Verification of Vital Events (EVVE) national web-based query system to obtain electronic birth certificate records for applicants born in states other than Iowa.

Description: Citizenship and identity verification became a Medicaid requirement on 7/1/06 due to the passage of the Deficit Reduction Act of 2005. Currently, Iowa's Birth Certificate Verification (BCV) system allows DHS to obtain an electronic birth certificate match from the IDPH vital statistics office to individuals born in Iowa. BCV currently produces valid matches on 96% of requests and it takes an average of 3.22 days to get a response back. The EVVE system would allow individuals born in other states to benefit from the efficiencies of verifying citizenship through data matching rather than the delays and costs involved in securing a paper birth certificate.

Legal References: 42 CFR 435.406 and 435.407; 441 IAC 75.11(2)"f"

Experience of Other States:
Michigan: Already has a database that allows data matching of Michigan births. The system is able to provide a match approximately 70% of the time. They have received a Medicaid Transformation Grant that will upgrade several technologies, including revising the Medicaid eligibility intake worker interface to improve birth fact validation.

Pros and Cons: (source: NAPHSIS website, correspondence with IDPH; need to contact NAPHSIS for technical assistance or further information about steps needed to implement & costs)
Pros:

- Application processing time will be reduced for individuals who match through EVVE. Although most of these individuals may have eventually been approved after the family was able to obtain a paper birth certificate or alternative citizenship document, the efficiencies of the EVVE matching system offer the advantages of avoiding delays in benefits, preventing the need for families to make multiple visits or contacts to the DHS office, and decreasing applicants' frustration with the process.
- Saves worker time.
- Presumptive eligibility for children may not be practical if application processing times are reduced. However, whenever dropoff from PE to full Medicaid is due to the family not obtaining citizenship proof, EVVE matching would increase the application approval rate.
- Has been successfully piloted and tested in many states with DMVs and SS offices. Some Medicaid agencies are also using.
- Thirty-eight states already have 95-100% of their birth records back to 1935 available electronically. The other 12 states have less than 95% available but the capacity exists to have those records available by 12/09 if fully funded by the Department of Homeland Security. (source: NAPHSIS power points)

- The National Association of Public Health Statistics and Information Systems (NAPHSIS) is responsible for EVVE. All necessary security, confidentiality, and legal requirements will be managed by NAPHSIS.
- The EVVE system integrates easily with legacy systems and internet-based interface is also available. Web-based point of access is referred to as ADAM – searches through web may be free of charge.
- Single point of contact to obtain citizenship verification in all other states.
- If no exact match is found, the system executes alternate queries. NAPHSIS works with vital records offices on no-matches
- EVVE pilot with Medicaid offices in 6 states produced response times averaging 3-5 seconds.
- Although Real ID (see also Intelligence Reform Act of 2004) may eventually allow DHS to use a DLIC match as verification of citizenship, most children would not benefit from this and would still be better served by direct EVVE matching.

Cons:

- Match rates would depend on the integrity of data maintained by each state's own vital records office. While all states are required by federal legislation to implement, states are all at different points in the process and each have unique data integrity problems they are addressing. There is no federal funding to state vital records offices to implement, so that is also impacting each state's ability to comply.
- Match rates on certifications are lower than those on verifications. Match rates are highly dependent on the accuracy and detail of birth information obtained from the customer. The data fields collected from families needed to successfully match on EVVE will be more detailed than those needed for BCV. This could require changing DHS forms and IM training.
- There will likely be costs for each query as well as system start-up costs with NAPHSIS.
- Because Iowa already has BCV, it may not be cost effective for us to add EVVE if we don't have many applicants born in other states who are unable to get Medicaid due to citizenship proof requirements.
- There are many documents that can be used to verify citizenship. If most people are able to get these, paying the cost for matching with EVVE may not be worth it.
- EVVE would only verify citizenship. Individuals will still have to provide identity verification. This can be an Affidavit of Identity for children under 16, so the only kids that would still be denied are those whose parent/guardian does not follow up to provide this form.
- Likely requires an MOU or other agreement with NAPHSIS.
- Does not appear that the BCV system can be used to provide a front-end point of access to the EVVE system. Instead, workers would do an independent web-based query through EVVE for out-of-state birth records. This requires workers to learn and use a separate system.

- This will have no impact on securing Medicaid for eligible alien children or for children who are citizens through naturalization, adoption, or derivative citizenship based on a parent's citizenship.
- If Iowa adopts a presumptive eligibility for children program, the benefits of EVVE matching may be reduced (since the kids would be covered under PE which would allow time for the family to obtain the birth cert on their own).

Administrative Issues: IT staff or administrative staff time may be required to implement and maintain system or agreements to use NAPHSIS system. Workers would have to gather precise information about the person's birth in order to query the system for a positive match.

There will be costs and time associated with the following:

- Manual
- Forms
- Pamphlets
- Training
- MOU

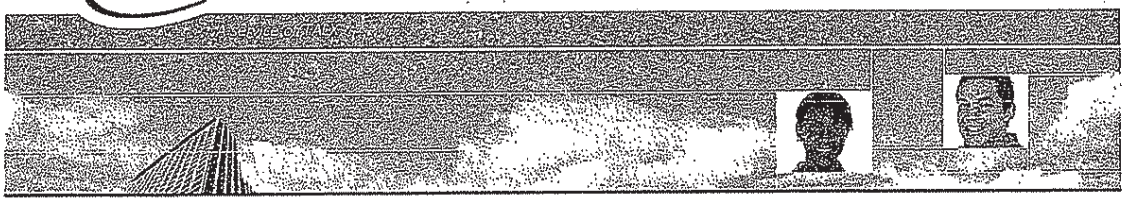
Fiscal Impact: Anticipated fiscal impact could be significant, primarily due to initial costs of implementing the needed technology. Ongoing fiscal impact of transferring the costs for matching records to DHS when these same records are already available to the customer for a fee to them.

Increased Medicaid enrollment achieved may impact the need for additional field staff although the efficiency of EVVE matching may actually save worker time.

Data from IME: There are currently 151,537 Iowa-born children in the Medicaid system (148,493 active and 3,044 canceled/denied) vs 38,451 children born in U.S. states other than Iowa (37,515 active and 936 canceled/denied). Data is not available on the number of children canceled/denied specifically due to lacking proof of citizenship/identity.

Attachment H: TALX

Attachment M



Government Services from The Work Number

Situation

Accurately enrolling clients is critical to administering public assistance today. But, that requires current employment and wage information that many state and federal databases lack. Using outdated wage data to set benefit levels leads to over- or under-payments and puts agencies at risk for fraud and abuse.

Solution

To reduce that risk, The Work Number® offers current employment and income verifications, available instantly with a Social Security Number search. The Work Number's government services deliver real-time employment and wage information to the desktop with no delay or waiting for a fax. It all starts with a client SSN and can be delivered in three ways:

- **Express** – instant, online delivery
- **Batch** – rapid delivery for large caseloads
- **Integration** – seamless delivery into your back-end technology

The Work Number is used best in tandem with state and federal data sources to confirm stated income on an application. It offers a unique ability to uncover unreported employment and earnings that you won't find elsewhere. Plus, The Work Number includes additional wage details required for public assistance and self-sufficiency programs, like hours worked and income-by-pay-period, to help you track work participation.

Government service users also access an expanded employer base totalling 1,750 nationwide – representing over 30% of the working population.

Employment & Income Verification

- Employer name & address
- Employee name & job title
- Job Status – active; inactive
- Current pay rates
- Most recent hire date
- Total time with employer
- Hours worked per pay period
- Wages by pay period (up to 36-month history)

Value

Join states like New York, Ohio, Washington and Missouri who already use The Work Number's government services in their daily process to verify eligibility, recertify clients or perform fraud and quality checks. These agencies all benefit from an added layer of accuracy in distributing benefits to the most eligible clients ... and that results in improved program performance!

Benefits:

- Confirm current employment & income
- Access most recent pay rate & hours worked
- Uncover unreported income
- Run regular performance integrity checks
- Monitor job participation & retention

To learn more or to see if you qualify to "pilot" our service, please contact your Sales or Client Relationship Manager at 1-800-888-8277 or e-mail govinfo@theworknumber.com.

continued . . .

TALX

Functional Overview: Government Services

As agencies have become more adept in data matching, The Work Number® has made it easier for employment and income information to be integrated into the public assistance workflow process.

Service Descriptions:

Access The Work Number data in more than one way, starting with a Social Security number:

Express	Batch	Integration
• Verify employment individually • Get verifications, instantly, online • Search database with a client SSN	• High volume case exchange • Rapid turn around • Frequent or periodic matches performed	• Connect with any application • Flag data for caseworker review • Seamlessly run every case against the data

Flexible Options:

To maximize performance, mix and match our services to address a variety of your needs.

		Our Agency Caseworkers			
		Determine Eligibility	Perform Reviews	Monitor Client Participation	Uncover Fraud
We verify employment and income:	As individuals enroll	Express	Express	Express	Express
	On enrollees & groups of participants	Express & Batch	Express & Batch	Express & Batch	Express & Batch
	Automatically in case management system	Integration	Integration	Integration	Integration

Cost-Effective Rates:

The Work Number's government services are fee-based and provide a strong return to your agency. Whether you perform online verifications or you batch a large file, you pay only for a "match" – authentic, current employment and income information as of the last pay period.

Contact us today: 1-800-888-8277 or e-mail govinfo@theworknumber.com.

TALX

Attachment I: Technology

Attachment I: Technology

Proposal: To pursue further technology enhancements that will allow DHS' eligibility system to:

- communicate with other data systems for the purposes of establishing eligibility,
- verify customer information,
- allow customers the ability to check on the status of their applications, and
- allow customers to report changes or check benefits online.

Description: System upgrades (OASIS) currently nearing completion and expected for rollout in the fall of 2008 already provide significant enhancements to DHS' capabilities. These improvements will make an application available online which customers can use to apply for multiple benefit programs including Medicaid, FIP, and FA. This application can be submitted 24/7 and will provide real time potential eligibility feedback based on their statements on the application. Customers will now be able to file the application online through the single electronic signature component. Medical providers, school personnel, and others can assist a customer in applying for DHS' benefits from any site with web access. Additional enhancements proposed would further improve access for customers.

Legal References: NA

Experience of Other States:
Arizona: Web-based application system implemented 10/08 allows application to be screened for multiple programs. It can be submitted online with electronic signature (login, password, acceptance of the conditions for applying and for applying on line). Because case records are also electronic, if applicant has fax available they can fax and electronically associate verification documents with the application. Enhancements immediately following will include the ability to make changes and complete redeterminations online. (source: 8/08 meditators email from Arizona staff) Also developing a web-based health information exchange that will provide access to an electronic health record which includes, among other data, Medicaid eligibility information; this project is still in planning phase.
Wisconsin: Online application includes a screening tool individuals can use to quickly and easily determine potential eligibility for several programs before an application is submitted. Recipients can check their benefits and report changes online. (source: 8/08 meditators email from Wisconsin staff, **www.access.wisconsin.gov**). These components were brought up in stages over 2-3 years with funding from a USDA grant to build system. Was an early user of middleware system technology and is now into more challenging phase of dealing with business jurisdictional issues (source: e-health snapshot article, May 2007)
Alabama: Already has joint online application with electronic signature option, single hospital system has been built and is currently being piloted so that demographic information the hospital gathers at intake is automatically input into Medicaid's web-

based system when initial screening shows family may be income eligible. (source: video from 5/08 NASHP presentation)
Michigan: Electronic application can be completed in 25 minutes, system prompts for missing information and provides immediate potential eligibility feedback, does require print & mail in signature page. (source: *Covering Kids & Families* Promising Practices Report, Southern Institute on Children and Families, April 2007)
Pennsylvania: COMPASS system allows families to apply for and renew coverage for multiple programs online in multiple languages 24/7, "smart system" asks only relevant questions. (source: e-health snapshot article, May 2007)
Utah: eFind provides eligibility workers with filtered and organized information from 18 different federal/state/local data sources with one simple search that takes 5-15 seconds, initial cost of $2 million to build system was shared across agencies and saves millions in staff time annually. (source; e-health snapshot article, May 2007)

Pros and Cons:
Pros:

- Easier access of eligibility information for applicants and members
- Reduces phone calls to workers or the call center
- Save worker time – workers must currently access a minimum of 8-10 different systems for each household member to search for income/resources at application. This takes an average of 20-30 minutes per household.
- DDM is already working to create more "connectors" between disparate systems that would allow DHS systems to data match with other systems e.g. SS, CS, IWD, WIC, school lunch, etc. without requiring querying of programs or other manual actions by staff (e.g. some states have systems that allow eligibility workers to receive a report within a few minutes that lists the person's other income sources rather than our process of doing lookups into each separate system. This will happen gradually over the next 2-3 years as the eligibility system is migrated off the mainframe. (source: 8/08 email from Sandy Paris)
- DDM is already considering adding functionality to the online system which would allow customers to report changes or check benefits online. This would become feasible after migration of the eligibility system off the mainframe is complete in 2-3 years. (source: 8/08 email from DHS IT staff)
- DDM is already working on OASIS phase 2 which will allow online application to interface with applications from other sources (e.g. WIC, well child care, assistance for pregnant women). When an applicant for one program indicates an interest in a separate program, a system interface available in 2009 will allow the sharing of enough information so that the other agency can follow up by contacting the applicant.
- Customers without internet access can still apply by paper application.
- May increase access for isolated populations (e.g. rural, disabled, elderly).
- Accessibility of web-based system attracts new community partners (e.g. hospitals, providers, schools) to provide application assistance which benefits customers and saves DHS worker time.

Cons:

- Costs of new systems or technology
- Until the migration of the eligibility system off the mainframe is complete, will not have the functionality to proceed with many of these enhancements without significant expense and additional FTEs due to the complexity of managing the security issues while the eligibility system is on the mainframe. The timeline, staffing, and budget for the project migrating these off the mainframe or completing related enhancements is not controlled by DHS program eligibility staff.
- Safeguards must be taken to protect identifying information and ensure matching the right individual when using data matches for enrollment/verification.

Administrative Issues:

There may be costs and time associated with the following:

- Manual
- Rules
- Forms
- Pamphlets
- Training
- State Plan Amendment
- MOU

Fiscal Impact: No additional fiscal impact for projects noted that are already in the works. Anticipate significant fiscal impact for any technology enhancement needs beyond this.