

November 2013 | Issue Brief

Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion

INTRODUCTION

Beginning January 1, 2014, millions of low-income parents and other adults will become newly eligible for coverage in states implementing the Affordable Care Act's (ACA's) expansion of Medicaid to adults with incomes at or below 138% of the federal poverty level (FPL).¹ To help states launch the expansion and efficiently enroll eligible individuals, CMS has offered states a series of facilitated enrollment options. These options include strategies, referred to as "fast track enrollment" in this issue brief, that allow states to enroll eligible individuals into coverage using data already available from their Supplemental Nutrition Assistance programs (SNAP) and/or their Medicaid or Children's Health Insurance Program (CHIP) programs for children. These strategies complement the array of other pathways currently in place to connect Medicaid-eligible individuals to coverage, which include applying directly through state Medicaid agencies or through the new Marketplaces established by the ACA. To date, these fast track enrollment strategies have been implemented in four states: Arkansas², Illinois, Oregon, and West Virginia. New Jersey also recently secured approval to implement fast track enrollment and is scheduled to begin implementation in November.

This issue brief provides an overview of the new "fast track" enrollment options, including how they have been implemented, their impacts, and key lessons learned. It is based on a series of interviews with state officials in Arkansas, Illinois, Oregon, and West Virginia conducted by Manatt Health Solutions and the Kaiser Commission on Medicaid and the Uninsured. In sum it finds that

- Arkansas, Illinois, Oregon, and West Virginia together have already enrolled more than 223,000 people in coverage through these "fast track" options;
- Through these enrollment gains all four states reached a significant share of adults who will be eligible for the Medicaid expansion, providing a major one-time boost toward their enrollment goals;
- While implementing the fast track initiatives required upfront investments of time and effort, they paid off by simplifying the application and enrollment process for individuals and staff, as well as by reducing pressures on new eligibility and enrollment systems.
- The fast track initiatives have been positively received by both consumers and state enrollment staff.

BACKGROUND

On May 17, 2013, the U.S. Department of Health and Human Services (HHS) sent a letter to State Medicaid Directors and State Health Officials advising them of options available to facilitate the enrollment of eligible individuals into Medicaid.³ Two of the options, referred to as “fast track” enrollment in this brief, allow states to use data that they already have on hand to identify and enroll eligible people into Medicaid.⁴ The fast track options draw on earlier experiences with Express Lane Eligibility and share many key elements with the deemed enrollment of Medicaid beneficiaries into the low-income subsidy for Medicare Part D.⁵ They provide states with an efficient way to make progress toward their Medicaid enrollment goals at a time when they are busy implementing the Medicaid expansion; establishing or coordinating with new Marketplaces; and launching new eligibility and enrollment systems. States can apply for approval to use either of these options at any time prior to the end of calendar year 2015.

Specifically, under the new “fast-track” enrollment options states may:

- **Use SNAP data to identify people who are likely eligible for Medicaid.** SNAP generally provides benefits to individuals with incomes up to 130% FPL and uses a rigorous process to verify eligibility. As a result, it provides a source of reliable information to identify individuals who meet income eligibility criteria under the Medicaid expansion.⁶ While there are some modest differences in the definition of income in Medicaid versus SNAP, under the new enrollment option, states may obtain a time-limited waiver to rely on SNAP findings to identify individuals who are eligible for Medicaid. When using SNAP data to facilitate Medicaid enrollment, states still must determine eligibility for non-financial components of eligibility, such as citizenship, in accordance with Medicaid requirements.
- **Identify parents who are likely eligible for Medicaid based on their children’s enrollment in coverage.** Nearly all parents expected to be eligible under the Medicaid expansion to adults have a child who already is enrolled in Medicaid or CHIP or could be enrolled.⁷ As a result, existing information about low-income families with children enrolled in Medicaid represents a robust source of data to identify parents eligible for the Medicaid expansion. Although the ACA changes how income will be counted for Medicaid, under this enrollment option, states can obtain a time-limited waiver that allows them to use existing information for families whose children are already enrolled in Medicaid to identify parents who will qualify for the Medicaid expansion.⁸ As with the SNAP option, states must gather and evaluate any additional data needed to determine if these parents meet non-financial Medicaid eligibility rules, such as citizenship and immigration status requirements.

Under both of these fast track enrollment options, the existing data sources jump-start the enrollment process by helping states identify income-eligible individuals. However, the options stop short of allowing states to automatically enroll SNAP beneficiaries or parents of Medicaid or CHIP children into Medicaid. States must take additional steps to ensure that individuals want to be enrolled in coverage and that the state has all of the necessary information to verify eligibility. For example, states must secure an application signature from eligible individuals; provide them with information on their rights and responsibilities; and verify their non-financial eligibility for coverage in accordance with Medicaid standards. In addition, within a year of their initial enrollment (or earlier if they report a change in circumstances), states must evaluate fast track enrollees using the new Medicaid income and household composition rules.

FINDINGS

ADOPTION OF FAST TRACK ENROLLMENT

As of November 15, 2013, five states with Medicaid expansions have received approval to use the fast track enrollment options, as shown in Table 1 below. (In Arkansas, the state is implementing a premium assistance model that allows Medicaid funds to be used to purchase Qualified Health Plans (QHPs) through the Marketplace for newly eligible adults.) All five use SNAP data to identify Medicaid-eligible individuals, and three (New Jersey, Oregon, and West Virginia) have also adopted the strategy to use Medicaid enrollment data for children to reach eligible parents. As of early November, four of the five states have implemented fast-track enrollment. New Jersey plans to begin implementation in mid-November. As noted, states may apply for approval to use either of these options at any time prior to the end of calendar year 2015, so additional states may take up the strategies moving forward.

| State | Using SNAP Data | Parents of Medicaid/CHIP Children | Implemented? |
|---------------|-----------------|-----------------------------------|---------------|
| Arkansas | Y | | Y |
| Illinois | Y | | Y |
| New Jersey | Y | Y | Nov. 15, 2013 |
| Oregon | Y | Y | Y |
| West Virginia | Y | Y | Y |

IMPLEMENTING FAST TRACK ENROLLMENT

While there are a number of variations in how the four states implemented the fast track enrollment options, they all followed several basic steps, which include the following:

- 1. Identify eligible individuals within existing, approved data sources.** All four states examined their SNAP enrollment data to identify individuals eligible for Medicaid. Two states (Oregon and West Virginia) also used their existing data on families with children enrolled in Medicaid to identify eligible parents (Table 2). Using these data sources, all four states selected individuals with incomes at or below the Medicaid expansion income limit who were not already enrolled in Medicaid. Arkansas, Oregon, and West Virginia included both parents and adults without dependent children (or “childless adults”) below the income eligibility limit. In contrast, Illinois solely focused on identifying eligible childless adults. The states used the fast track enrollment strategies primarily to reach adults eligible for the Medicaid expansion as of January 2014. However, Arkansas and West Virginia also elected to use fast-track to reach already eligible children who were not yet enrolled in Medicaid, who could begin receiving coverage immediately. Similarly, in some cases, these strategies also connected currently eligible parents to coverage.
- 2. Send eligible individuals a streamlined enrollment form.** After identifying eligible individuals, the states sent them a letter and a simple one- or two-page enrollment form (see Box 1). Individuals were required to answer a handful of questions about non-financial eligibility for coverage as needed to allow the states to verify their citizenship or immigration status, sign the form to indicate they wanted coverage and that they were aware of their rights and responsibilities, and then return it to the state.⁹ In some instances, the enrollment form asks for a few additional pieces of information, such as whether an individual has

coverage through an alternative source (to facilitate third party liability recovery efforts) or if a person is of American Indian descent (to assess whether he or she can be enrolled in managed care). People can return the form through the mail and, in Oregon and West Virginia, they also have the option to call a toll-free number and provide the necessary information and a telephonic signature over the phone.

**Table 2:
Key Features of State Fast Track Enrollment Strategies**

| State | Target SNAP Population | | | Modes to Return Enrollment Form | |
|---------------|------------------------|------------------|----------|---------------------------------|-------|
| | Parents | Childless Adults | Children | Mail | Phone |
| Arkansas | Y | Y | Y | Y | |
| Illinois | | Y | | Y | |
| Oregon | Y | Y | | Y | Y |
| West Virginia | Y | Y | Y | Y | Y |

3. Verify non- financial eligibility for coverage. After receiving the forms back, states verify the citizenship status of the individuals in accordance with Medicaid standards. In general, these standards require states to electronically verify the person’s status using the federal data services hub and, if citizenship cannot be established through this means, to rely on a paper verification process.¹⁰ Similarly, for non-citizens, if immigration has not yet been verified, the state will seek to verify status through available electronic data sources, or paper documentation when electronic data are not available. If citizenship or immigration information cannot be verified, the person is found ineligible for Medicaid.

States used a variety of strategies to streamline the processing of the returned enrollment forms. For example, West Virginia and Arkansas included bar codes on the forms so that eligibility workers could easily scan them into the state’s eligibility system when they were returned. Arkansas, Illinois and Oregon used their central processing units or set up a special team to verify and confirm eligibility. Illinois officials noted that having a handful of key people working on the initiative enabled them to quickly identify and resolve issues and allowed their other eligibility workers to focus on broader ACA implementation efforts.

Box 1:

Fast Track Enrollment Forms and Notices: A Consumer- Friendly Approach

All four states sought to make their fast-track enrollment forms and notices easy to read and use. For example, Oregon’s fast track notices were written in simple language, included significant white space, and were signed by the state’s Medicaid director, to highlight that there was a “real person” within the state agency behind the communication. The state also provided people with a self-addressed, stamped envelope to return their enrollment form.

In some instances, states faced technological barriers that limited the options they had available to design their notices and enrollment forms. In Oregon and West Virginia, for example, because of technological limitations, the states sent a separate enrollment form to each individual in a household who was identified as eligible for Medicaid rather than a single household form. But, states developed ways to compensate for limitations. For example, Illinois was limited in its ability adopt a consumer-friendly designs for its notices within its legacy computer system, so it accompanied the enrollment notice and form with a very easy-to-read one-page brochure.

Officials noted that while many consumers appreciated the short, easy-to-read forms and streamlined enrollment process, some contacted call centers or eligibility workers seeking confirmation that the forms were legitimate because they were surprised and skeptical about the ease of the enrollment process. To help address these issues, states included their official seal on fast track correspondence and a phone number that people could call for further information or clarification.

4. Confirm eligibility. After states complete the verification process, they send eligible people a notice confirming their eligibility and advising them that their coverage becomes effective starting January 1, 2014. Illinois and Oregon also included enrollment cards in this mailing. Officials noted that although individuals were advised that coverage would not begin until January 1, some consumers thought their coverage was immediately effective and tried to use it upon receiving their eligibility confirmation. To minimize this problem, the states highlighted the January 1, 2014 effective date of coverage whenever possible, often mentioning it multiple times in the same letter to consumers. West Virginia is attempting to avoid this confusion among consumers by waiting until closer to the effective coverage date to send eligibility confirmations and enrollment cards. In the interim, it is notifying consumers that it has received their enrollment form and that they will receive their determination in December 2013.

5. Facilitate enrollment into health plan. In Illinois and West Virginia, Medicaid beneficiaries generally are provided with services through a fee-for-service delivery system. In Oregon, however, adults enrolled in the Medicaid expansion select a coordinated care organization from which to receive services while in Arkansas they select a QHP offered through the Marketplace. As such, both of these states also provide individuals information on how to select a plan with their enrollment confirmation. If new enrollees do not select a plan within the state's required timeframe, they are automatically enrolled in a plan by the state.

All four states view fast track enrollment primarily as a time-limited strategy for facilitating early enrollment into their new Medicaid expansion. In the weeks and months remaining in 2013, Arkansas, Oregon and West Virginia are conducting "second round" mailings and/or calling people who did not respond to the first mailing to ensure the correspondence was not overlooked or misplaced. They also are developing procedures to address changes in circumstances prior to January 1, 2014 and planning to re-verify that fast track enrollees are not already enrolled in Medicaid shortly before their coverage goes into effect on January 1, 2014. At this point, none of the four states are planning to use fast track on an ongoing basis.

ENROLLMENT OUTCOMES TO DATE

To date, approximately 223,000 people in these four states have been enrolled in Medicaid through these fast-track enrollment efforts. Enrollment numbers range from 35,500 in Illinois to 63,465 in Arkansas (Table 3, next page). These numbers in Arkansas and West Virginia include some currently eligible children who were immediately connected to coverage through these initiatives. The states are continuing to process all returned enrollment forms, so these enrollment numbers will likely continue to increase as the states finalize verification and processing of all returned forms. Through these enrollment gains, the fast track enrollment strategies have enabled all four states to make significant progress in reaching and enrolling individuals eligible under the Medicaid expansion. For example, the number of people determined eligible for Medicaid through fast track in less than two months represents 18% of Illinois' first-year Medicaid enrollment goal of 200,000 and one-quarter of the total coverage goal of 250,000 in Arkansas. In Oregon, state officials report that fast track enrollment has reduced the number of uninsured people in the state by 10% in less than one month.

All four states had robust response rates among individuals who received the fast track enrollment letters. Response rates to the initial letters and enrollment forms varied from 27% in Oregon to 46% in West Virginia. State officials noted that they were surprised and encouraged by these high levels of

response. Moreover, since Arkansas, Oregon, and West Virginia sent or plan to send a follow-up letter or communication to individuals that did not respond to the initial letter, these response rates may continue to increase. For example, eligibility workers in Arkansas and West Virginia are calling people at home if they did not respond to the initial letter. In Arkansas, eligibility workers reported having a hard time reaching people by phone but, when they did, roughly 90% indicated they wanted the coverage. Since the state accepts telephonic signatures for the fast track enrollment form, eligibility workers are able to promptly enroll people over the phone. Other factors may also impact the response rate in these states including the level of unmet need for health care services and the states' Medicaid eligibility levels prior to the Medicaid expansion.

**Table 3:
Fast Track Enrollment Outcomes Reported November 15, 2013**

| State | Date Enrollment Form Sent | Number Receiving Enrollment Form | Percent of Forms Returned to State | Number of People Verified as Eligible and Enrolled |
|---------------|---------------------------|----------------------------------|------------------------------------|--|
| Arkansas | September 3, 2013 | 154,000 | 41% | 63,465 |
| Illinois | August 23, 2013 | 123,000 | 33% | 35,500 |
| Oregon | September 30, 2013 | 260,000 | 27% | 70,000 |
| West Virginia | Early September 2013 | 118,000 | 46% | 54,100 |
| Total | | 655,000 | | 223,065 |

Notes: The number of individuals receiving the enrollment form includes 9,000 children in Arkansas, 30,000 parents of children enrolled in Medicaid in Oregon, and 28,046 parents of children enrolled in Medicaid in West Virginia. Illinois has 2,300 returned forms remaining that need to be processed. In Arkansas and West Virginia the number of people verified and enrolled includes children currently eligible for coverage. Additionally, in the three states that targeted parents using SNAP data, some parents may be eligible under current rules.

LESSONS LEARNED

Each state took some steps to tailor its fast track initiative to its unique circumstances, including the structure of its eligibility rules and enrollment system and its overall ACA communication and outreach efforts. However, some common “lessons learned” can be drawn from the four states’ experiences.

While implementing these fast track initiatives required upfront investments of time and effort, they paid off with substantial coverage gains while minimizing the burden on individuals, staff, and enrollment systems. As noted, implementing the fast track enrollment strategies did require upfront investments of time and effort to identify the target populations and send out and process enrollment forms. However, state officials unequivocally indicated that these investments were worth it. From the state perspective, they generated substantial gains in coverage in a short time frame while minimizing burdens on individuals, eligibility workers, and enrollment assisters and reducing traffic to the new Marketplace enrollment systems.

"It was quick and easy, gave us the biggest bang for the buck, and it was easy for staff to manage."

"We were looking for a way to not create duplicative work for the eligible clients and to meet guiding principles to reduce waste and inefficiency in the health care system. So requiring someone to reapply when we know their income and situation would be a waste."

The fast track initiative has been a positive experience for both consumers and state enrollment staff. As indicated by the high response rate to the fast track enrollment letters, consumers were highly motivated to enroll through this streamlined approach. State officials reported that consumers expressed gratitude for both the availability of coverage under the expansion and the ease of the fast track enrollment process, sometimes by attaching thank you notes to their enrollment forms. Enrollment staff also welcomed the streamlined enrollment approach, and state officials indicated that eligibility workers felt positive about being able to quickly confirm eligibility for many consumers who they would have denied in the past under eligibility rules prior to the Medicaid expansion. Finally, state officials highlighted that fast track enrollment has helped to acclimate their eligibility workers to the new, data-driven approach to evaluating Medicaid eligibility required by the Affordable Care Act.

"Make it simple and seamless and any way you want to apply without having to sit and produce all of this documentation. It has been a real cultural shift for our county workers. This is the changing face of Medicaid. Things aren't working the way they used to work."

"...for years they've had to say "no" to people...and now they just get to say "yes" you can have coverage."

The fast track enrollment initiative can be integrated into broader ACA outreach and enrollment initiatives. To varying degrees, the four states sought to integrate their fast track enrollment initiatives into broader ACA outreach and enrollment efforts. For example, Oregon adopted a marketing-based approach to implementing its fast track initiative -- it developed a special section on its web site to share information, trained Navigators and other assisters on fast track, designed consumer-friendly forms, and included a marketing brochure along with the enrollment form it sent to consumers.¹¹ Arkansas used its state Marketplace logo, "Get In," on its enrollment form to help ensure that consumers would connect fast track enrollment with the state's larger initiatives to enroll people into Medicaid and Marketplace coverage. It also included a note on its enrollment form alerting consumers that other uninsured family members who were not being enrolled under the fast track initiative can still apply for new coverage options online.

In conclusion, the experience of these four states demonstrates that fast track strategies represent a highly effective enrollment option for states. By using data already available to them and drawing on their expertise with eligibility and enrollment systems, these four states have been able to jump-start enrollment into their Medicaid expansions, enrolling more than 221,000 people in just two months. As result, they have made substantial progress toward their Medicaid enrollment goals while minimizing burdens on individuals, staff, and enrollment systems.

This brief was prepared by Jocelyn Guyer and Tanya Schwartz with Manatt Health Solutions and Samantha Artiga with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The authors extend their deep appreciation to the state officials who shared their time and expertise to inform this work, as well as to Donna Cohen Ross and Deborah Bachrach for their careful review of and comments on this issue brief.

ENDNOTES

¹The Affordable Care Act requires states to apply a 5 percentage point of the FPL disregard to the new adult group, effectively increasing the income threshold for the Medicaid expansion from 133% to 138% of the federal poverty level (FPL).

² Arkansas is using a premium assistance model for its coverage expansion. Under the model, known as the “private option” within the state, Arkansas is using Medicaid funds to enroll newly eligible adults into Qualified Health Plans (QHPs) offered through its new Marketplace.

³ State Health Official Letter. Centers for Medicare & Medicaid Services. May 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>.

⁴ Other options included in the May 2013 letter, but not discussed in this paper include: 1) implementing the early adoption of Modified Adjusted Gross Income (MAGI), 2) extending Medicaid renewals scheduled to take place during the first calendar year of 2014, and 3) adopting 12-month continuous eligibility for parents and other adults.

⁵ Under Express Lane, an option established by the Children’s Health Insurance Program Reauthorization Act, states may use information from programs such as SNAP, Temporary Assistance for Needy Families (TANF), Head Start, and Women, Infants, and Children (WIC) to identify children who meet Medicaid criteria so that families do not have to resubmit the same information to multiple programs. As with the new fast track enrollment option, states still must verify citizenship and immigration status in accordance with Medicaid standards. Similarly, after the Medicare Modernization Act established the Medicare Part D benefit and an accompanying low-income subsidy program, the Department of Health and Human Services elected to deem “partial benefit” Medicaid beneficiaries as eligible for the low-income subsidy program. While the eligibility rules for the low-income subsidy differ from those used in Medicaid, HHS determined that it would be administratively efficient to simply deem these individuals as automatically eligible for the low-income subsidy.

⁶ According to HHS's May 17th letter, "Recent studies by both the Center on Budget and Policy Priorities and the Urban Institute find that, despite the differences in household composition and income-counting rules, the vast majority of non-elderly, non-disabled individuals who receive SNAP benefits are very likely also to be financially eligible for Medicaid."

⁷ Martha Heberlein, et. al. “Medicaid Coverage for Parents under the Affordable Care Act.” Georgetown University Health Policy Institute Center on Children and Families, June 2012. Available at: <http://ccf.georgetown.edu/wp-content/uploads/2012/08/Medicaid-Coverage-for-Parents.pdf>.

⁸ Under the ACA, financial eligibility determinations for Medicaid, CHIP, and premium tax credits and cost sharing reductions for Marketplace coverage will be based on Modified Adjusted Gross Income (MAGI). MAGI is based on IRS definitions of what counts as income after selected deductions are taken into account.

⁹ States are required to comply with Medicaid citizenship verification requirements when processing fast track applications. As a result, states must re-verify the citizenship status of fast track applicants using Medicaid (rather than SNAP) procedures. In addition, those states (Oregon and West Virginia) that are enrolling the parents of Medicaid children in coverage must verify their citizenship or immigration status in accordance with Medicaid requirements.

¹⁰ The federal data services hub connects states to common federal data sources (including but not limited to Social Security Administration, Internal Revenue Service, and Department of Homeland Security) to verify consumer application information for income, citizenship, and immigration status.

¹¹ Fast Track to Oregon Health Plan Materials are available at: <http://www.oregon.gov/oha/healthplan/pages/fast-track.aspx>.