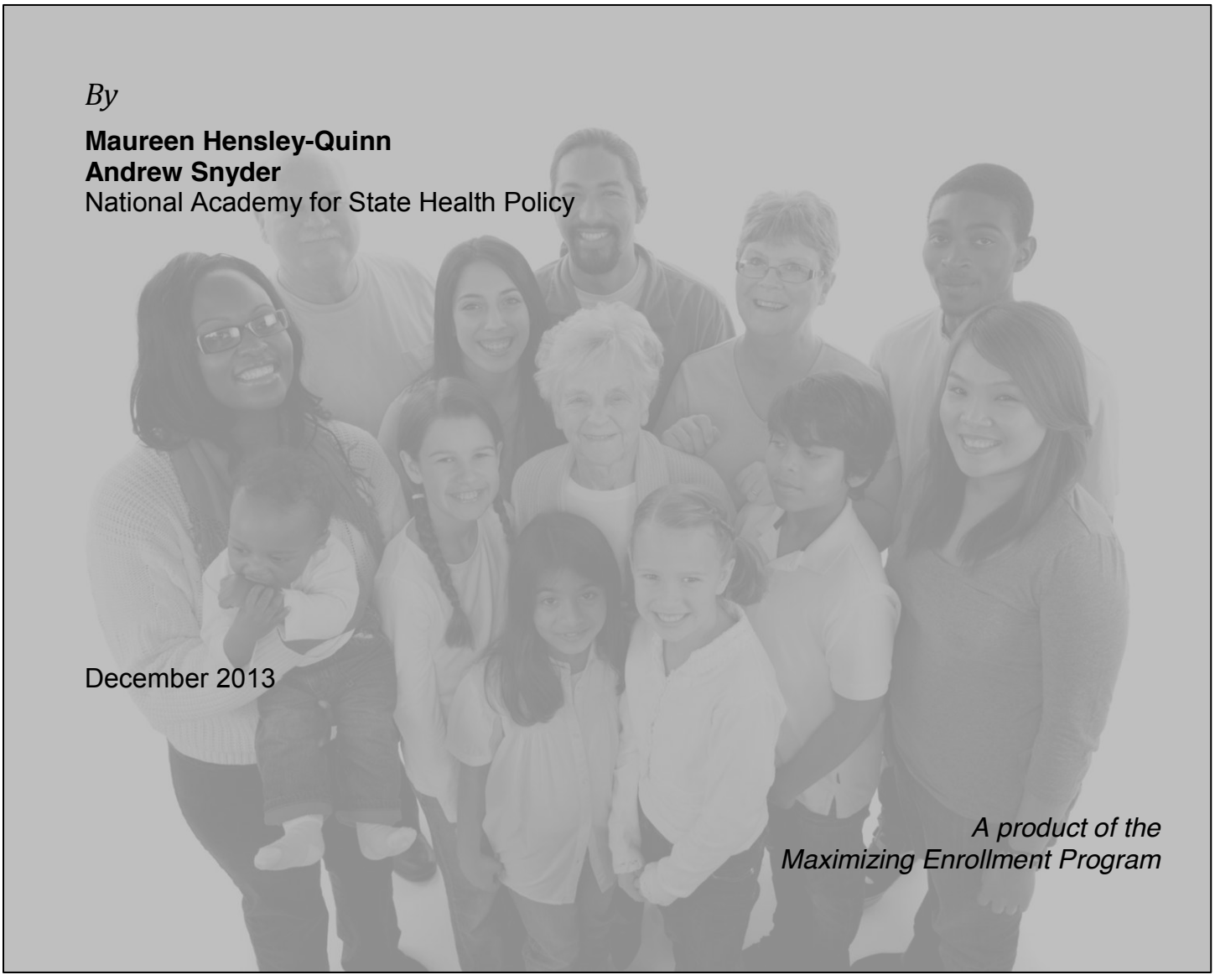
Managing Program Change: Experience From Maximizing Enrollment States in Leadership, Culture Change, Coordination and Data

A Maximizing Enrollment Report

By

Maureen Hensley-Quinn
Andrew Snyder
National Academy for State Health Policy



December 2013

A product of the Maximizing Enrollment Program

NATIONAL ACADEMY for STATE HEALTH POLICY®

Robert Wood Johnson Foundation

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

About Maximizing Enrollment

Maximizing Enrollment has worked intensively with eight states to improve eligibility and enrollment systems, policies and procedures. This report examines how states pursued programmatic change by bringing together three key strategies: providing leadership to achieve culture change, improving data analysis to target and track policy changes, and focusing on coordination across the various state and local entities administer eligibility systems.

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and nonpartisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues. Our funders include both public and private organizations that contract for our services. For more information, visit www.nashp.org.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.

For more information, please contact Maureen Hensley-Quinn at mhq@nashp.org or (202) 903-2782.

Acknowledgements

The authors wish to thank the Maximizing Enrollment state team members from Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin whose work and reflections informed this report, and who offered valuable insights in the review process. We would also like to specifically acknowledge Alice Weiss, Catherine Hess and Alan Weil at the National Academy for State Health Policy (NASHP), and Tricia Brooks, Mary Harrington, and Vicki Grant for their editorial review. We particularly wish to thank Nicole Dunifon, Program Assistant at NASHP, for her excellent research and technical support that was invaluable to the paper. Finally, we thank Andrew Hyman and Lori Grubstein at the Robert Wood Johnson Foundation for their continued guidance of the Maximizing Enrollment national program and whose vision and commitment to the program have ensured that we have findings to share.

December 2013

Dear Reader,

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

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

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

- Harness technology to make enrollment more simple, efficient and accessible;
- Manage programmatic change through committed leadership that sets a consistent vision for coverage, using data to drive policy changes, and coordinating across programs, agencies and local entities that share responsibility for health and human services programs, and
- Simplify and streamline processes to reduce unnecessary paperwork and relieve burden on both applicants and eligibility workers.

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

Sincerely,

Catherine Hess
Co-Director
Maximizing Enrollment

Alice Weiss
Co-Director
Maximizing Enrollment

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

TABLE OF CONTENTS

Executive Summary

Since 2009, the eight states (Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin) participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program have worked to streamline eligibility and enrollment systems for children and those eligible for coverage in 2014. Throughout the program, state teams needed to manage programmatic change due to their own streamlining efforts, as well as respond to a recession, elections, and the enactment of major federal laws including the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act (ACA).

In making these changes, each of the Maximizing Enrollment states pursued multiple strategies to work toward the state's health coverage vision by weaving together three key components of change: 1) providing leadership to achieve culture change; 2) improving analysis and use of data; and 3) focusing on agency and program coordination.

This report, the second in a series of reports highlighting lessons learned from Maximizing Enrollment, examines how states brought each of these strategies together into a tapestry of change management that supported the states' overall health coverage vision and goals for streamlining systems, policies and procedures.

Maximizing Enrollment states emphasized multiple organizational factors to support committed leadership. Each of the eight states participated in a diagnostic assessment, and used the results of that inventory to create a plan that captured their vision and goals for covering eligible individuals and operating more consumer-focused eligibility and enrollment processes. States worked to:

- *Articulate a clear vision* to provide parameters for determining improvement goals and directing state activities. Several states set their goal as enrolling all eligible children in the state, while others like Massachusetts, focused on covering families – children and their parents.
- *Engage and cultivate leadership support*, particularly at the governor's office, cabinet, or agency levels, to cultivate champions for health coverage. Virginia found that the development of a steering committee to advise on the work of the initiative, chaired by the state's Secretary of Human Resources, was important. The steering committee not only provided the Secretary with a defined role within the state's grant project, but also helped to engage the leadership of multiple agencies whose partnership was important to the project's success.
- *Engage stakeholders* to gain external support and input on policy changes, as well as to assist with reaching those eligible for coverage programs. Alabama worked with the state's Covering Kids and Families coalition to solicit feedback on its online application, spread information throughout the state about its Express Lane Eligibility initiative, and engage key constituencies on budgetary issues.
- *Align culture with vision* by engaging staff at all levels to strengthen ongoing communication through focus groups and in-person meetings; as well as clarifying expectations by standardizing performance measurement across offices. Louisiana was an early leader in developing a culture of coverage, with a focus on ensuring that frontline workers understood their role in the state's vision for health coverage.

Maximizing Enrollment states worked to meaningfully measure Medicaid and Children's Health Insurance Plan (CHIP) program performance and then used that data to inform program decision-making. Maximizing Enrollment provided data collection support and structure to grantee states through process mapping, monthly data reports, and development of standard performance

measures. Maximizing Enrollment states pursued a variety of activities to develop an analytic agenda for continued improvement, including work to:

- *Improve analytic capacity* and standardize statewide data collection. Virginia established a workgroup to identify policy-relevant questions they had about enrollment data. These questions guided the development of performance measures, a data warehouse and a dashboard that shares data with workers across the state.
- *Track denial and disenrollment reasons* to understand why individuals were losing coverage. Massachusetts used enrollment data to craft targeted policies to reduce disenrollments due to missing paperwork, reducing gaps in coverage and burden on eligibility staff.
- *Dedicate data analysis staff* to assist states in analyzing enrollment and retention data. Utah and Virginia each used grant funds to support data analysts who helped state leaders to better understand and act on the data being collected.
- *Collect data on consumer experience* to identify potential enrollment barriers, gain a different perspective on state health coverage programs, and inform future simplifications. Utah conducted focus groups and a survey of clients, and found that a majority preferred online applications, and contact through e-mail – which informed the state's use of e-mail to prompt clients to log on to their secure accounts to view important notifications.
- *Enhance use of external data sources* to utilize information collected outside state's Medicaid and CHIP programs in order to better understand the characteristics of the clients they serve. Virginia used data from the American Community Survey to identify counties with high concentrations of uninsured individuals, and as a result targeted enrollment strategies in those areas.
- *Develop enrollment and retention measurement* within the context of the ACA. Measures developed through Maximizing Enrollment helped states prepare to track new federal measures of enrollment, retention, customer satisfaction and disenrollment.

Building effective connections across the multiple state and local agencies and programs that have a role in enrollment is critical in managing change and sustaining gains. Maximizing Enrollment states' models for determining eligibility vary widely. In some states Medicaid eligibility is centralized and administered by one state agency, others operate a decentralized process operated by local or county offices. Some use systems where Medicaid and other human services programs are very separate; other states administer systems where multiple programs are completely integrated. In all cases, however, coordination was a critical component to achieving and sustaining change, particularly in states that operate integrated health and human services systems administrated at state and local levels. States worked to:

- *Collaborate and integrate across programs* to ensure enrollment and retention simplifications made to systems, processes and procedures were coordinated and communicated among multiple program or agency offices. Determining a method or process for decision-making and clarifying roles and responsibilities among the various parties aided in coordinating programs that have complementary goals, but different priorities.
- *Coordinate between state and local offices* to effectively communicate and divide responsibilities for the Medicaid program between the state and local offices to make consistent eligibility determinations and successfully enroll and retain those eligible for coverage. New York and Wisconsin re-envisioned state and local office Medicaid responsibilities and began implementing changes during the Maximizing Enrollment program.

Lessons for Other States: The transformations that the ACA requires have big implications for how states set their policy priorities, engage leadership, measure their progress, and coordinate their work across agencies and programs. By looking across the many threads of programmatic change that

Maximizing Enrollment grantee states pursued, several key lessons emerge that may offer value to other states in the midst of ACA implementation.

- *Leadership Can Prioritize Resources*: Commitment from high-level leadership from the Governor's Office or from a cabinet secretary for streamlining health coverage systems and policies is essential to achieving sustained programmatic changes.
- *Establish Shared Goals:* Establishing shared goals among the various state and local agencies that have a hand in administering health coverage programs provides a foundation for ongoing engagement. Maximizing Enrollment states found that focusing initial discussions on the shared goal of finding ways to increase program efficiency helped to engage multiple parties.
- *Institute Regular Communication:* Finding ways to institutionalize communication between partnering programs and agencies is necessary to maintain and build on gains made. Several grantee states created work groups that included representatives from multiple agencies or across programs to work together toward group- identified goals through the project period. These workgroups are not dependent on a single individual, so representation from different programs can evolve over time as needed.
- *Design Systems to Capture Usable Data:* As states overhaul their decades-old eligibility systems to comply with the ACA, it is beneficial for states to build in data-collection systems that will focus on a few key indicators that are precise enough to be understandable, but general enough to be actionable.
- *Exploit All Your Information Systems:* Grantee states tracked quantitative data on enrollment and retention and took advantage of the move from paper-based applications to an electronic application system to better understand application processing times and hang-ups in the determination process. States also looked beyond internal administrative data to get a variety of perspectives on which aspects of their programs were working and which ones weren't.
- *Culture Change is Ongoing:* One official in Louisiana defined agency culture as "the way we do things around here." As programmatic and technological changes occur as a result of health reform, the grantee states took this opportunity to not fall into a new pattern of "things we do because that's what we do," and instead strived to maintain focus on continuous improvement, and sustained attention to the hard, time-consuming work of orienting to a culture of coverage.

Future Directions: States may want to consider additional strategies for the future, including: integrating health and human services eligibility and enrollment by either linking or coordinating across multiple public benefit programs that serve the same low-income families; continuing to redefine the roles of state agencies, local agencies, and community-based organizations; and tracking performance across programs to develop enrollee identifiers and measures of performance that look across Medicaid, CHIP and health insurance marketplaces to get a complete picture of whether individuals are able to move seamlessly between programs, and where snags may be occurring.

The following report shares the successes and challenges the grantee states experienced as they managed programmatic changes in each of the three areas. States considering ways to achieve their own strategic goals around enrollment policy will benefit from the lessons Maximizing Enrollment states learned through the program.

Introduction

"Don't eliminate the possibility of changing something just because that's the way you've always done it, people will surprise you based on how you frame it."

- Kate Honsberger, Virginia's Maximizing Enrollment Grant Coordinator

In 2009, eight states received grants from the Robert Wood Johnson Foundation as part of the Maximizing Enrollment program to increase enrollment and retention of eligible children into Medicaid and the Children's Health Insurance Program (CHIP) and to establish and promote best practices in streamlining eligibility and enrollment systems, policies and procedures to share with other states. With the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, the Foundation expanded the goal of the program to encompass state strategies to modernize eligibility, enrollment and retention policies to prepare for newly eligible individuals in 2014. Through the four years of the program, the Maximizing Enrollment state teams needed to manage programmatic change due to their own streamlining efforts, as well as changes resulting from political elections and enactment of federal laws with major impacts on state health coverage, including the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA, all during a multi-year national recession.

The Maximizing Enrollment states pursued multiple strategies to effectively manage, and in some cases leverage, the substantial changes occurring during the program to help them work toward their streamlining and simplification goals for health coverage systems, policies and procedures. As threads of different colors are woven together to make a pattern for a tapestry, the Maximizing Enrollment states incorporated different elements that work together to realize the state's health coverage vision. The three threads of this change management tapestry included:

- *Providing leadership to achieve culture change* that includes articulating a clear vision for the state to inform goals for improvement and help to create an environment that supports engagement of internal and external stakeholders.
- *Analyzing and using data* that supports informed decision-making as a result of understanding enrollment and renewal trends as well as the consumer experience.
- *Coordinating across agencies and programs* and between state and local offices to be efficient and effective in serving eligible families' benefits needs.

This report, the second in a series of reports that highlight activities of the eight states and explore their lessons learned from Maximizing Enrollment, will examine the states' tapestry of change management by reviewing each of these three threads. While the threads are explored separately within this report to highlight the states' strategies, all of the strands are part of the same fabric, working together to support the states' overall health coverage vision and goals for streamlining systems, policies and procedures. The report begins with background on state experience prior to Maximizing Enrollment in managing change and notes some of the changes needed. The report then provides a discussion of the key areas of state work in each of the three threads of the states' change management tapestry, providing examples and models for other states. Finally, the report offers lessons learned and possible future directions to support additional work in this area. While the information shared here is derived from state experience in Maximizing Enrollment, this experience offers important strategies and paradigms that are highly replicable and can add value as all states implement transformational changes to Medicaid, CHIP, and exchange programs under the ACA in the coming years. This report seeks to highlight and offer these ideas as a model to all states for inspiration in this work.

Background

During the first year of Maximizing Enrollment, the states participated in a diagnostic assessment to identify strengths, challenges and opportunities for improvement within their enrollment and renewal systems, policies and procedures. The standardized assessment included multiple components: a review of each states' enrollment and renewal data; collection and analysis of written documentation detailing eligibility, enrollment and renewal policies; creation of flow charts mapping enrollment and renewal processes; and site visits to each state to conduct interviews with multiple stakeholders both inside and outside state Medicaid and the Children's Health Insurance Program (CHIP) agencies. Each state received an individual assessment and these findings were summarized in a final report.[1] The assessment process and results confirmed previous National Academy for State Health Policy (NASHP) research about the value of key management strategies that are critical to making system, policy and procedural changes to minimize barriers and increase enrollment of those who are eligible. The importance of committed leadership to support agency culture and the role of data in making informed decisions and coordinating across agencies and programs had not received much attention in research, but state experience shows these operational strategies are critical.

The diagnostic assessment was confirming for most states – both in identifying strengths and opportunities for improvement. Managing programmatic changes, both large and small, is not new to states; for most state officials, managing change is a part of everyday work, so each state brought strengths to Maximizing Enrollment. All states started the Maximizing Enrollment program with support from committed leaders to streamline and simplify enrollment and renewal for those eligible. The assessment noted that a couple states, in spite of older eligibility systems, made strides in collecting and using data to make strategic program decisions. Prior to Maximizing Enrollment, Virginia adopted a coordinated, "no wrong door" approach to enrollment in its Medicaid and CHIP programs that allowed families to apply for coverage in any office regardless of the program type or location.

While governor's administrations in most of the states had shown support and commitment to covering eligible children, the assessment found that achieving and sustaining a culture of coverage was varied across states and programs. Also, for several states, the assessment identified improving data collection and analysis as a priority, citing a lack of reliable data the reasons that individuals were disenrolled from Medicaid and CHIP. Legacy eligibility systems played a significant role both in the lack of enrollment trend data and for challenges coordinating across programs, agencies and offices because the systems didn't allow for seamless data transfers. As a result, children moving between health coverage programs due to eligibility changes could lose coverage, churning off and back on to health programs. The assessment also noted the potential for inconsistencies in processes, resources, and implementation of enrollment and renewal policies across local offices for a number of Maximizing Enrollment states, which could result in highly varied consumer experiences throughout the state. The issues identified by the assessment were not unique to Maximizing Enrollment states, other states likely still face similar challenges, so all states may find this report useful as it explores the strategies employed to strengthen the states' change management tapestry.

Key Areas of State Work

Provide Leadership to Achieve Culture Change

> **"Nothing implements itself. Leadership is important. You need to have a strategy [for making programmatic changes], and a really solid plan. You must set ego aside, and have everyone working toward the same goal."**
> - Casey Erikson, Utah

Every tapestry begins with two things—an idea of the picture the weaver wants to create, and the warp, the strong structural strands that support the rest of the design. Leadership serves both those functions in states' change management tapestry. This section focuses on several organizational factors that influenced Maximizing Enrollment states' success in effectively and efficiently enrolling those eligible in public health coverage: vision, leadership, internal and external partnerships and agency culture.

Articulate a Clear Vision: First, we'll explore how the Maximizing Enrollment states developed and articulated a vision that guided their program work. Each Maximizing Enrollment state, with assistance from National Academy for State Health Policy (NASHP) staff and expert consultants, participated in a diagnostic assessment identifying strengths, challenges and opportunities for improvement that provided a framework for each states' activities throughout the program. Following the diagnostic assessment, each state developed goals for their work and a work plan to implement those goals. While each state's vision was unique and specific, all states shared a commitment to improving enrollment and retention, largely by operating more streamlined, efficient programs. Several states articulated their vision as the intention to cover all eligible children or individuals. Many of the states envisioned operating more consumer-focused eligibility and enrollment processes.

Essentially, the states' visions for their enrollment systems provided boundaries or guardrails for determining improvement goals and helped direct the states' activities. One example how a state used its vision to define program goals and strategies can be seen in Massachusetts. Massachusetts' health care vision is to cover all individuals. As a part of that vision, the state focuses on ensuring families—parents as well as their children—are enrolled in the health coverage for which they are eligible. This focus on coverage for the whole family as a goal meant that, even though state officials at Massachusetts' integrated Medicaid (MassHealth) and Children's Health Insurance Program (CHIP) agency were interested in adopting Express Lane Eligibility (ELE),[2] the state did not immediately pursue using the option because the strategy was originally only permitted for children. Intent on finding a way to design ELE to work for families, MassHealth worked with the state's Department of Transitional Assistance, the agency that oversees the Supplemental Nutrition Assistance Program (SNAP), to design the ELE process for parents and children. MassHealth included the use of ELE to renew coverage for parents enrolled in SNAP in the state's 1115 waiver submitted in December 2011, then in early 2012, followed up with a state plan amendment to take up the ELE option for the children of those parents. As a result, MassHealth was able to use its broad coverage vision to define priorities and effectuate an ELE strategy that aligns with and supports the state's vision for coverage and will support simplified renewals in 2014 and beyond.[3]

The states' Maximizing Enrollment teams, which typically consisted of Medicaid and CHIP program staff, not only used their vision and goals to frame their work, but also as a tool to engage internal and external stakeholders in the program work. Several Maximizing Enrollment states reported that having a clear vision for the work or explicit goal to share with stakeholders helped in forming partnerships and made the work easier. Virginia's Maximizing Enrollment team seized the opportunity to use the vision and goals of the program for internal and external stakeholder engagement, as well as a tool for accountability. After the second and third year of the program, Virginia's Maximizing Enrollment team

created a two-page document that highlighted the state's accomplishments within each of their four key improvement goals. The two-page document was shared with the many stakeholders the Virginia Maximizing Enrollment team engaged throughout the program, including state leadership, Medicaid and CHIP program officials and county and non-governmental partners. The document served three purposes: 1) to reiterate the state team's vision and goals to help their partners stay connected to the program; 2) to share the activities tied to each key goal, which helped with accountability for the team and their partners; and 3) to allow celebration of accomplishments. Additional information on ways the participating Maximizing Enrollment states engaged leaders and stakeholders is discussed later in this section.

Maximizing Enrollment states found that both having a clearly articulated vision of the goals for change, and using that vision to define their work and create accountability with stakeholders was a powerful way to maintain focus on streamlined enrollment or improved enrollment outcomes as a goal. Other states may find that having a similarly well-defined vision of the states' goals and using those goals to help prioritize policy changes and promote capacity to track and celebrate progress may be useful in their ACA implementation work.

Engage and Cultivate Leader Support: Engaging and cultivating leaders at all levels of state organizations proved to be another important element in Maximizing Enrollment states' work on providing the leadership needed to accomplish the systems, policy and culture change that states set out to do in this program. The theme of leadership and its value to state success is one that emerged in earlier NASHP work, including at a symposium soliciting experts on successful strategies to cover children.[4] Experts at the symposium cited the importance of visible, high- level leadership support for health coverage, finding that "[States] need to have a champion for coverage."[5] Understanding the critical role leaders play in the success of health coverage initiatives, the Robert Wood Johnson Foundation required Maximizing Enrollment states to submit letters of support from their state administration as part of their initial proposal to participate in the program. This requirement was designed to promote involvement and commitment of high-level state and agency leaders to the states' enrollment system transformation. In this way, commitment and involvement of state leaders was an essential element of the Maximizing Enrollment state experience, especially as state leadership changed over the course of the grant. In addition, a common experience that emerged among Maximizing Enrollment states over the grant was the value and contribution that mid- and junior-level leaders can play in managing program change work.

*Managing Leadership Changes***:** Leadership at the cabinet or agency levels proved to be an important component of all states' efforts to manage program changes and achieve improvements throughout Maximizing Enrollment. There were gubernatorial elections in all of the eight Maximizing Enrollment states from June 2008, when the states submitted their proposals with letters of state administration support to participate in the program, through the end of the states' grants in 2013. Six of the eight states (Alabama, Illinois[6], New York, Utah[7], Virginia and Wisconsin) experienced gubernatorial transitions that in most cases also affected leadership at cabinet and agency levels as well. For the states with new governors, the Robert Wood Johnson Foundation requested an updated letter of commitment for the program goals to ensure continued leadership support and the Maximizing Enrollment state teams engaged their new administration. Each of the six states experienced the administration transition differently, but all ultimately received support for continuing to transform their state's eligibility and enrollment systems. Virginia's administration change turned out to be a critical turning point for their Maximizing Enrollment program work and their experience navigating this change may be instructive for other states seeking to cultivate and sustain institutional support through leadership changes.

Figure 1: Overview of Maximizing Enrollment State Administration Changes 2008 to 2012

State	2008 Governor	Political Party Affiliation	Gubernatorial Elections		
			Year of Election	Governor Elected	Political Party Affiliation
Alabama	Bob Riley	Republican	2010	Robert J. Bentley	Republican
Illinois	Rod Blagojevich	Democrat	2010	Pat Quinn[1]	Democrat
Louisiana	Bobby Jindal	Republican	*No Change in Administration*		
Massachusetts	Deval Patrick	Democrat	*No Change in Administration*		
New York	David Paterson	Democrat	2010	Andrew Cuomo	Democrat
Utah	Jon Huntsman Jr.	Republican	2012	Gary Herbert[2]	Republican
Virginia	Tim Kaine	Democrat	2009	Bob McDonnell	Republican
Wisconsin	Jim Doyle	Democrat	2010	Scott Walker	Republican

[1] Quinn assumed governorship in 2009, after Blagojevich was impeached and removed from office. The incumbent Quinn won election to a full term in 2010.
[2] Herbert assumed the governorship in 2009 following the resignation of Governor Huntsman, who was appointed the U.S Ambassador to China. He was elected to serve out the remainder of the term in a special election in 2010. The incumbent Herbert won election to a full year term in 2012.

Virginia submitted its proposal to participate in the Maximizing Enrollment program in June 2008 with the support of Democratic Governor Tim Kaine and was awarded the grant in February 2009. After the state project team spent the initial year of the program participating in the diagnostic assessment and identifying the state's vision and goals for the work, newly elected Republican Governor Bob McDonnell took office. The vision the Virginia team had developed was to improve the efficiency of the Medicaid and CHIP eligibility and enrollment systems, policies and procedures with a strong focus on improving the collection and analysis of data to guide and evaluate improvements. The state's project team was unsure if the new administration would embrace this vision and participate in the initiative. Key members of the Virginia Maximizing Enrollment team met with the new Secretary of Health and Human Resources (HHR) to brief him on the diagnostic assessment results, share the project vision and gauge his interest. In doing so, they framed the vision and goals on the efficiencies the project team hoped to achieve, which was supported by the neutral, unbiased diagnostic assessment report, focusing on the positive impact to state programs, workers and citizens. The new administration embraced the vision and encouraged the Maximizing Enrollment team to seek ways to use technology to help achieve the goals and promote further system efficiencies. As a result, Virginia's Maximizing Enrollment initiative implemented a number of technological advancements that, without the administration's support, may not have happened. The Secretary took on a very active role in the initiative and encouraged directors of multiple agencies, including Medicaid and the Department of Social Services – both integral to transforming the state's eligibility systems, to actively participate and encourage their staff to do so as well.

Engaging Leadership Through Governance Structure

Virginia's Maximizing Enrollment team strategically established a governance structure for their initiative as part of their grant proposal. The proposal called for the creation of a Steering Committee, chaired by the HHS Secretary, which encouraged not only the engagement of state administration leadership, but also leadership from multiple state agencies. The Steering Committee met on a bi-annual basis, which provided the state team with regular opportunities to update the committee and importantly, the HHS Secretary, on activities and accomplishments. The Steering Committee included the Commissioners of the Department of Social Services (DSS) and the Department of Health (DOH), the Director of the Department of Medical Services (DMAS), and the Superintendent of the Department of Education. The Committee provided a foundation to support the coordinated implementation of changes aimed at improving enrollment and renewal systems, policies and processes for children that all of these agencies serve, and ensured that political leaders would be involved and engaged in project implementation work. Reflecting on lessons from Virginia's initiative, Cindy Olson, Eligibility Policy Manager, of DMAS said, "If we hadn't written the Executive Steering Committee, chaired by the Secretary, into the grant, I don't think we would have been able to get all those agency directors in the same room. The committee helped legitimize their participation." Other states are adopting this type of structure to manage their change initiatives. Multi-agency committees or working groups have been created and by all accounts in many states[8] also have been important to help make decisions to implement ACA.

Cultivating Mid-Level Project Management Leaders: Maximizing Enrollment state officials reported and NASHP observed throughout the initiative that agency directors and mid-level managers are often critically important to managing and sustaining changes to systems and policies. Agency level leaders, such as Medicaid and CHIP directors, are in a position to better understand how changes impact their programs. In most of the Maximizing Enrollment states, either the Medicaid or CHIP director served as their state's lead for the initiative. Most of the Maximizing Enrollment states also named a project manager for their grant programs - someone in a mid-level position that reported to either the Medicaid or CHIP director who was dedicated to managing the project's work plan and budget. NASHP observed throughout the program that the more effective project managers were given a fair amount of autonomy and ownership to coordinate different aspects of state grant activity. Fostering leadership at the project management level has proven critical in some Maximizing Enrollment states' success in achieving meaningful programmatic changes related to eligibility and enrollment.

Louisiana, Virginia and Massachusetts offer good examples of encouraging leadership in those dedicated to managing the state's grant project. Louisiana's Maximizing Enrollment team consisted of many state Medicaid and CHIP officials with different responsibilities related to eligibility and enrollment. Both the Medicaid and CHIP Directors played leadership roles for the team, but the project manager hired to coordinate all of the grant program activity played a critical role in ensuring the state's capacity to track and accomplish key initiatives. Louisiana's Maximizing Enrollment project manager was responsible for ensuring that tasks within the state's work plan were accomplished and that the state adhered to the grant budget. The agency directors provided the grant's project manager with guidance, but depended on her to lead team meetings, ensure that different working groups of staff officials prioritized the grant activities, and to represent the state team at external meetings. Similarly, both Massachusetts and Virginia Maximizing Enrollment state teams invested in project leaders who were empowered to coordinate activities as well as take on a leadership roles within the state team and with external partners. Each of the three Maximizing Enrollment states reported

tremendous value in having someone dedicated to the management of their grant program, including the intangible benefit of having someone who could sustain momentum and focus on specific goals and hold others accountable. While resource constraints may challenge other states' ability to have dedicated program management staff, the successful experience of these three states' investment in a project manager does illustrate the opportunities and benefits of having clearly assigned a staffer with responsibility coupled with authority that can be adapted to support state implementation of the ACA.

Engage Stakeholders: In addition to the importance of the factors already discussed, another common factor in state success to managing programmatic change was engaging stakeholders.[9] Examples of the kind of stakeholders that experts have recommended states include (in policymaking activity to support and promote coverage) include: schools, community-based organizations, foundations, businesses and health care providers. All of the Maximizing Enrollment states had relationships with stakeholders prior to and throughout the grant period, though relationships varied across the different states and stakeholders. Most of the Maximizing Enrollment states partnered with community-based organizations to help with outreach for coverage programs and, in many cases, with in-person application assistance as well. Activities and experiences in Alabama, Massachusetts and New York are discussed here to illustrate how regularly engaging stakeholders can provide states with external support or input for policy changes, and perspectives to better support the consumer eligibility and enrollment experience.

Building on Covering Kids and Families Network: Alabama's stakeholder engagement work has been built on a strong foundation developed from their involvement in the Robert Wood Johnson Foundation's Covering Kids and Families, a national initiative to improve access to coverage for children and families that supported coalitions of stakeholders in all 50 states and Washington, DC.[10] Although the national initiative ended in 2007, Alabama's Covering Alabama Kids and Families (CAKF) remains active. CAKF is a coalition comprised of advocacy leaders, non-profit organizations, business and community leaders, provider groups and others that are committed to increasing access to health coverage for children and families. Representatives from Alabama's Medicaid and separate CHIP programs participate in the CAKF coalition meetings held quarterly to provide policy and program updates and answer coalition member questions. These meetings provided a locus for exchanging information, allowing state officials to report out, gain valuable inputs on developing policy and gain political support for their work. Over the course of Maximizing Enrollment, the coalition members learned about state investments to improve the online health coverage application, offered feedback to the state and shared information with their constituents when the new application was launched. Medicaid officials were able to inform the group about ELE implementation, to celebrate periodic wins through sharing the updates, and gain the support of the coalition for this strategy.[11] The coalition's support for Medicaid and CHIP programs provided an important ballast during the ongoing state fiscal crisis that coincided with the national recession. Because CAKF members were so well informed about the Medicaid and CHIP programs, they were able to educate elected officials during budget negotiations and promote public support for a referendum ballot question that helped stave off deep funding cuts for Medicaid.

Promoting a Continuous Feedback Loop: Massachusetts' models for monitoring stakeholder interests and keeping stakeholders informed during its implementation of reform in 2006 and in later years may be useful to other states implementing reforms. MassHealth officials take a variety of approaches to get inputs from stakeholders, including regularly meeting with community-based organizations, advocates and providers. To ensure ongoing communication, MassHealth has institutionalized monthly meetings with advocates that serve to inform the state about what is happening in the community, better understand the consumer perspective, and for the state to share out policy, operational and legislative activity from MassHealth and the Connector (the state's health insurance exchange). A MassHealth administrator reports the value of establishing a working relationship with

advocates to identify areas of consumer need; these meetings also provide an opportunity for the state and advocates to "keep a pulse on any changes in policy that might impact applicants and members." To support their effort to keep both agency workers and other stakeholders informed during their implementation of health reforms, MassHealth established quarterly training forums to take place in five regions around the state to communicate accurate, timely information about operations and policies for all state health coverage programs to community health and human service partners. At each quarterly forum, the same trainer shares the same information with the group and takes questions, then later posts a list of all the questions and answers received at the forums for all to access as a way of promoting transparency and consistency. MassHealth sees the benefits of these forums to be: sharing information to enhance attendee's ability to assist individuals enrolled and those applying for coverage; opportunity for inter-active roundtable discussions; and building collaborative relationships to better serve individuals.

Using Stakeholder Inputs to Shape Consumer-Facing Tools: New York's Department of Health (DOH) engages stakeholders regularly and worked intensively with stakeholder representatives to support improving their paper application early in Maximizing Enrollment. In 2009, New York eliminated the requirement for an in-person interview when applying for health coverage. As a result, applicants no longer needed to meet with an eligibility worker to complete an application, so the state wanted to ensure the application was understandable for applicants with or without assistance. State officials reached out and formed a working group with a number of knowledgeable advocates and community-based organizations to review and offer suggestions for revising the application. A separate work group was established with local districts to review the revised applications and develop policies for processing applications at local districts. Organizations within the advocate working group also did some user testing of the questions by giving the revamped application to members of the target audience, potential applicants, to review and comment on readability of the application. The state appreciated the assistance from the stakeholders and thought the end product was better for having external perspectives. The opportunity to work together on the task also helped to further improve relationships between the state and some members of the working group.

All of these examples illustrate the potential benefits to the state of actively engaging stakeholders in program change work. These benefits can include improving their conduit for information to report on program changes; increasing inputs on how the program changes are being experienced from program participants; improving relationships with stakeholder organizations; gaining political support for program changes; and being able to leverage stakeholders as advocates for options the state cannot publicly support. Engaging stakeholders can be invaluable in weaving a states' tapestry of programmatic change and has clear application to states' current ACA implementation work.

Align Culture With Vision: Changing agency culture was another vital component of state efforts in Maximizing Enrollment. Maximizing Enrollment states reported that refocusing agency culture to one that supports coverage and promotes consumer assistance is essential to fulfilling a state's goals and reaching the vision for enrolling people who are eligible. This culture of coverage contrasts with a traditional welfare-based model where, in placing a greater emphasis on program integrity and protecting the program from erroneous enrollment, stringent policies and procedures erect barriers that can inadvertently keep out eligible individuals. Supporting a culture of coverage was a recurring theme throughout the Maximizing Enrollment initiative and all eight states included it as a focus within their grant work to varying degrees.

"We can advance a culture of coverage when:

- **Needless administrative activities are eliminated;**
- **Necessary administrative activities are as simple as possible;**
- **Communications are clear;**
- **All stakeholders are heard and valued;**
- **Participation has social and health rewards."**

  - Robin Callahan, Mass.

Prior to initiating their work in Maximizing Enrollment, both Massachusetts and Louisiana had established a culture of coverage and focused on engaging frontline workers to ensure they understood their role in the state's health coverage vision. Administrators from both states reported educating staff at all levels about the importance of health coverage in peoples' lives by noting that coverage has both social and health rewards for families, particularly for those living in poverty. States with experience in aligning agency culture with the state's vision for simplified enrollment attest that efforts must be ongoing. Experience from Massachusetts and Louisiana offer two different examples of strategies states can employ to support an ongoing culture of coverage.

Acknowledging Impact: In 2011, Maximizing Enrollment state teams observed one of Massachusetts' low-tech, low cost strategies for supporting a culture of coverage on a site visit to the state's Central Processing Unit (CPU). The office had posted an erasable white board that was regularly updated throughout the day with the number of applications and renewals received and the number that have been processed. The director of the CPU explained that the white board tallies are a simple way to remind the eligibility staff of the impact they have daily on peoples' lives. The daily enrollment statistics are used as motivation and are considered something to celebrate at the MassHealth CPU. This connection between staff's daily work and those they are serving underscored to the entire office the goal of their work was increasing those enrolled.

"Three Tries" for Renewals: In addition to implementing numerous renewal simplification policies that require minimal response from consumers to renew their coverage, Louisiana also modified how workers process renewals. Louisiana requires all eligibility staff attempt to contact those who haven't responded to necessary inquiries or requests for information needed to complete a renewal at least three times at different times of the day. Before closing a consumer's case, a supervisor must review the file to ensure the "three tries" to contact the consumer have been made. This process underscores for the eligibility staff that retention of eligible individuals is important to the agency and the staff has a responsibility to assist consumers in maintaining their coverage. Louisiana reports its commitment to retention is part of Medicaid and CHIP agency culture, a point of pride for eligibility workers, and is reflected in the states' consistently low percentage (below 1.5%[12]) of cases closed each month as a result of not having information needed to complete the review.

Focus Groups: The Virginia Maximizing Enrollment team conducted focus groups with frontline eligibility workers in 2010. The state team was hoping the focus groups would initiate a process to improve relationships between the Department of Medical Assistance Services (DMAS), which is responsible for Medicaid and CHIP policy and operation, and the local Department of Social Services (DSS) offices that are responsible for determining eligibility for multiple programs, including Medicaid, SNAP and the Temporary Assistance for Needy Families (TANF). Virginia found the groups to be successful in initiating an ongoing dialogue between the central Medicaid office and local eligibility staff. Alabama and Louisiana used the same method of engagement following Virginia's model and conducted similar focus groups in 2012.

Through the focus groups all three states engaged eligibility workers and their supervisors in three areas: 1) staff challenges with enrollment and retention processes; 2) staff perceptions of enrollment barriers for the consumers; and 3) ideas for improvements. The states contracted with Mike Perry, a communications and focus group expert to develop questions and conduct the discussions. The results of the group discussions were shared with program administrators in the form of a report and Power Point presentation and then shared across agencies, programs and offices at multiple levels. Findings from the focus groups helped Medicaid and CHIP administrators better understand the challenges at the local office level and provided the frontline staff with a voice, which individual staff said they appreciated. Frontline staff also offered useful information that the state could act on to alleviate some of the burden felt by frontline workers. But most importantly, in all three states that employed this strategy, the group results provided state administrators with a platform for future

communication that according to states built trust and improved communication and staff morale. This model is highly replicable and may be a useful means for achieving similar goals, especially for states where eligibility is administered through local offices.

In-Person Meetings: Although in-person meetings between frontline eligibility staff and state Medicaid administrators took different forms in different states during the Maximizing Enrollment grant period, the goal was the same – continued engagement of all staff to improve communication and promote a culture of coverage. In Louisiana, a Deputy Medicaid Director traveled to hold meetings in each parish with local workers. In Virginia, DMAS, the state agency responsible for both Medicaid and the separate CHIP program, convened a statewide Health Care Summit that drew over 220 people from 55 localities. The summit focused on children's coverage within health reform and included presentations from national health experts, as well as from the state's Secretary of Health and Human Services and the DSS Commissioner. There was also a presentation to share an updated timeline for rolling out a web portal that was connecting eligibility systems for different human services programs. DMAS received rave reviews from attendees, so considers the event a success. Virginia's DMAS continues to regularly engage local staff in meetings held at the central office and periodically sends central state staff to local office meetings to maintain communication. In both Virginia and Louisiana, the Medicaid offices engaged with local staff based on feedback from the focus groups.

Standardize Performance Across Offices: Utah and Louisiana reported developing standardized performance measures for the different types of eligibility staff positions within the state. The intent is to offer clear expectations for all staff regardless of the position's location within the state or the staff member's direct supervisor. Creating standardized performance measures is in line with recommendations from state and national experts that eligibility workers should be provided with tools to improve their ability to perform their jobs well.[13] Both Louisiana and Utah also developed standardized staff evaluations used to measure workers' performance across the state regardless of the program, agency or office for which they work. The two states developed the evaluations using the standardized performance measures for each job category within the agency. The states' goal was to encourage coordination and reduce variability across offices and programs.

Louisiana operates a state-run Medicaid program, implemented by local offices in parishes throughout the state for conducting eligibility determinations. The state also has a robust remote work program (known as Telework or Work from Home Program), in which as many as 42 percent of Medicaid staff participate.[14] The Telework program is available to select staff and requires that home office space meet certain specifications to ensure privacy of consumer case files. While this program serves as a reward to staff and saves the state money in office space, it can be a challenge for supervisors of remote staff. The standardizing of policies and staff expectations to support a culture of coverage has been a valuable tool to support this program and reinforce the agency culture. Regardless of whether an eligibility worker is based in the state's central office, a parish office or at home, she is expected to follow the same policies and processes as her colleagues. Louisiana's Department of Health and Hospitals (DHH), the agency that oversees Medicaid, provides regular, ongoing training to workers through conference calls and webinars so everyone is hearing the same information. Also, during Maximizing Enrollment, DHH developed a new policies and procedures manual that is housed on an intranet available to staff. The new manual offers an easy search function that allows the user to type in key terms rather than clicking through pages of an online document. In these ways, Louisiana is able to promote and standardize the culture across their entire workforce, including virtual workspaces.

In Utah, the Department of Health (DOH) provides oversight for Medicaid and CHIP and contracts with the Department of Workforce Services (DWS) to administer the state's integrated eligibility system for all health and human services programs, including SNAP, TANF, and other programs. Eligibility staff is employed by DWS, but has responsibilities for determining eligibility for all the state's

human service programs. DOH and DWS work closely together to establish standard policies and procedures for staff to follow, and these procedures are used for all of the states' health and human service programs. Administrators of DOH and DWS are also working closely with the state's exchange lead. State officials from both agencies report that establishing clear roles and responsibilities among the agency administrators is important in developing policies and procedures that eligibility staff will follow. In Utah, the standardized performance measures are not only tools for frontline staff, but also for administrators in different agencies. In coordinating the development of the measures, the culture of each agency can be reflected and expectations for performance shared.

Analyzing and Using Information and Data

While providing leadership to support culture builds the structure for the programmatic change tapestry, strategic use of data is the thread that can help states to determine whether the pattern that is emerging captures the state's vision. The Maximizing Enrollment program strongly emphasized enhancing states' ability to use data to meaningfully measure Medicaid and CHIP program performance across a variety of dimensions to help inform program improvement efforts. This included not only collection of enrollment and process data, but also measurement of staff performance to help state officials answer concrete questions about how their programs are working and identify needed system, policy and procedure changes. Examples of those questions include:

- *Enrollment:* How many individuals are enrolling, and from what subpopulations?
- *Retention:* Once enrolled, how long do eligible individuals stay on the program?
- *Disenrollment and Churn:* When individuals leave the program, why is their eligibility terminated, and do they quickly return to the program? What role are state policies and procedures playing in churn and disenrollment?
- *Process:* How long does it take a program to process an application? What are the steps that add significant time to the application process, or that are the hardest for applicants to complete?
- *Consumer Experience:* How do applicants and beneficiaries experience the program and what barriers are impeding enrollment and retention?

For Maximizing Enrollment states, data became a lifeline that helped to drive policy decisions and helped states identify areas of focus for future work. Chris Trenholm and Mary Harrington, Maximizing Enrollment evaluators from Mathematica Policy Research, Inc. who consulted with states on data collection throughout the program, observed that knowing why a state makes progress, or why its progress differs from another, can be difficult. Behind the numbers that are collected are systems, culture, resources, and champions—as well as economics and demographics—that matter. Seeing progress, however, is easy. It only requires that states monitor and compare trends for useful measures, and getting to those useful measures requires:

- Quality, accessible data;
- Meaningful measures to track; and,
- Resources to turn data into validated measures.[15]

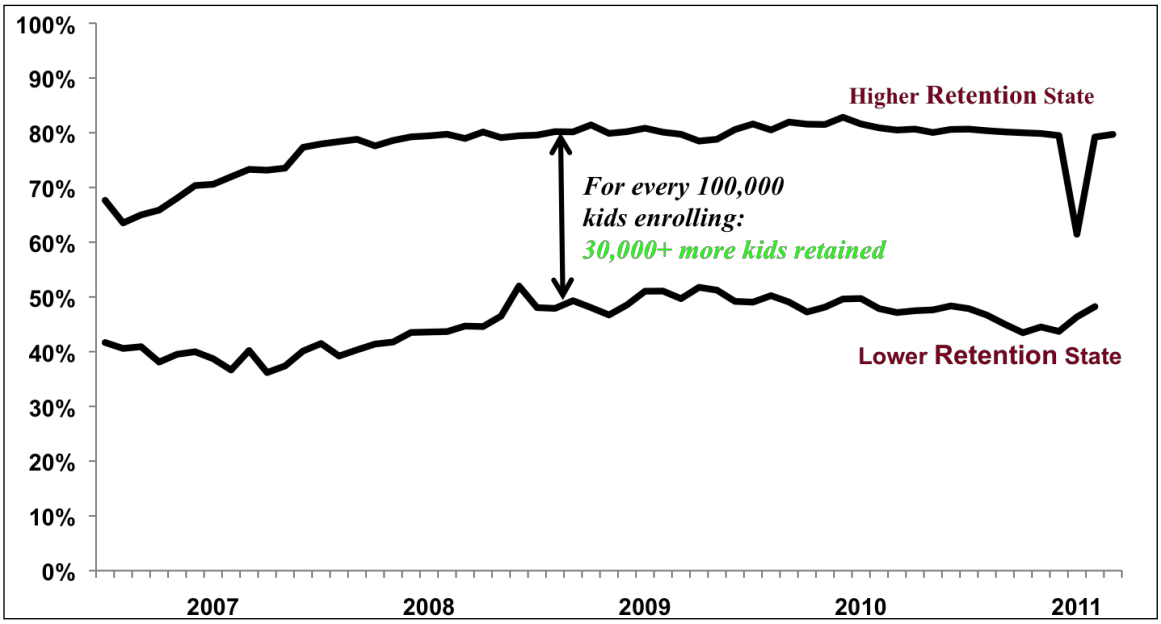
Virginia's Maximizing Enrollment Grant Coordinator Kate Honsberger, noted in reflecting on data's impact that data, "helps you prioritize. It informs policy or procedural changes, and also helps us figure out when a particular issue is not as big a problem as we thought it was." Her supervisor, Virginia CHIP and Maternal and Child Health Director and Maximizing Enrollment team lead Rebecca Mendoza also observed that, "data that paints a picture, it can be a motivator to get [local staff] to buy in to a new policy or procedure."

As all states embark on efforts to implement historic program and coverage changes, Maximizing Enrollment states' work and experience offers useful models that other states may want to consider. Maximizing Enrollment states pursued a variety of activities to develop an analytic agenda for continued improvement over the four years of the program. Six states—Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin—used Maximizing Enrollment funds to improve their internal data and enrollment trend reports. Virginia and Wisconsin used grant funds to improve their capacity to analyze data, and four others—Illinois, Louisiana, Massachusetts and Utah—pursued activities related to data analysis outside of the grant. Utah and Virginia used grant funds to directly support staff dedicated to data analysis. Common characteristics among state activities included: institutionalizing reports that gave the state usable data; using the reports to identify issues or problems that are amenable to policy solutions; and then monitoring the effects of policy changes. Highlighted here are a number of strategies and examples of Maximizing Enrollment states' work that may provide replicable models for other states.

Use Data Collection Tools and Structures: Maximizing Enrollment provided data collection supports and structure to grantee states that may be worthwhile for other states to invest time and resources in using or replicating:

- *Process Mapping Tool*: The initial Maximizing Enrollment diagnostic assessment that each state participated in included a detailed questionnaire, submission of data, interviews by program staff and consultants and a guided exercise where agency staff contributed to maps of every step of the state's enrollment and renewal processes. This process mapping exercise showed where there were gaps or duplication in their processes. Based on this assessment process, NASHP developed self-assessment tools for other states to use. Although the tools were developed in advance of the ACA, they may continue to be valuable for states to better understand their eligibility and enrollment systems, particularly given that case flow may change substantially in light of increased use of electronic applications, development of new eligibility IT systems, and transfer of cases between states' Medicaid and CHIP programs and newly established marketplaces. The tools are available on the Maximizing Enrollment website.[16]
- *Monthly Data Reports*: As part of their participation in the program, each state submitted baseline and monthly data on children enrolled in Medicaid and CHIP to the program's evaluator, Mathematica Policy Research, Inc. Mathematica researchers used those data to develop a series of simple but powerful reports that could facilitate comparisons of trends in enrollment, retention, and churn in a single state over time, and also allow comparison among states. For example, Figure 2 below illustrates the retention rate of children who entered the program and were continuously enrolled for 18 months in the highest- and lowest-performing Maximizing Enrollment states. The persistent 30 percentage point difference between the two states may point to policy variations that make a difference in whether a child has unbroken health coverage.
- *Policy and System Change Logs*: Every quarter, states submitted reports to NASHP documenting eligibility and enrollment policy changes and systems improvements. A log such as this can be useful when paired with administrative trend data in order to identify policy changes that may have had a measurable impact on enrollment.

Figure 2. Percentage of New Enrollees Continuously Covered 18+ Months in Two Maximizing Enrollment States



Source: Mathematica Policy Research, Inc. analysis of Maximizing Enrollment state data, 2013.

Develop Enrollment and Retention Measurement in the Context of ACA:
The 2011 Maximizing Enrollment report, *Using Data to Drive State Improvement in Enrollment and Retention Performance,* draws on Mathematica's experience with data collection in Maximizing Enrollment states to recommend 12 core performance measures. States can use these measures to monitor how long individuals stay covered once they are enrolled, track the results of eligibility-related policy changes and determine trends in program performance and track progress as they implement changes in eligibility and retention policies as they implement the ACA.[17] A companion brief describes a streamlined set of codes for denials and disenrollments intended to help states distinguish between cases closed because an individual was no longer eligible for coverage, those closed because of procedural reasons such as missing paperwork and cases closed for reasons not related to eligibility, such as non-payment of premiums.[18] These measures offer standards for states to consider in measuring eligibility, enrollment and retention performance over time.

Developing meaningful measures to monitor enrollment and retention is highly relevant to the ACA's reforms. Retention in public programs, particularly enrollment in Qualified Health Plans, is important not only because periods of uninsurance have negative health effects on individuals, but also because of the tax penalties that individuals who drop out of coverage might incur. Monitoring to ensure that individuals are able to successfully move between Medicaid, marketplace plans, and other sources of coverage in the course of a year will be important as states work to get closer to the ideal of seamless transitions and continuous coverage.

CMS is developing performance measures, and the analytic work that Maximizing Enrollment grantees participated in has informed those efforts, along with inputs from other researchers.[19] Federal oversight of eligibility and enrollment prior to the ACA focused on timeliness of eligibility determinations, and on identification of errors in the eligibility process. The new proposed measures are focused more on program-wide performance goals around enrollee experience, including measures of enrollment, retention, customer satisfaction and disenrollment.[20]

Improve Analytic Capacity: One of Virginia's priorities for its Maximizing Enrollment work was developing an analytic agenda to guide the collection of enrollment trend data through a data warehouse. The state established a work group that included representatives from relevant departments to identify policy and improvement-relevant questions they had about Medicaid and CHIP enrollment and retention. The work group's questions guided the development of performance measures that were important to both the state's central office as well as to the local offices. The state's new data warehouse software tool was designed to pull data from the Medicaid and CHIP eligibility systems (the state's separate CHIP program operated a different eligibility system from Medicaid) and from the Medicaid Management Information System to track progress on the established measures. The tool provided the state with the ability to run packaged reports, as well as to create customized ad hoc reports in a way that was previously not possible. Using the information now available from the data warehouse, Virginia also developed a dashboard that shares specific performance measures with staff. For instance, the dashboard can show up-to-date information on how many Medicaid clients have been renewed in a month or how many new applications have been processed. The dashboard serves to connect county offices that are spread across the state, and means that eligibility workers in every county can have up-to-date information on the number of applications and renewals that are processed.

Track Denial and Disenrollment Reasons: Louisiana had a history of using reporting tools that analyzed enrollment trend data to facilitate decision-making before beginning the Maximizing Enrollment grant and built on those structures in their work. As a result, Louisiana was able to monitor the effects of policy changes, and identify the causes of upticks or downturns in enrollment. For example, a dip in enrollment was traced to a policy change in the state's Express Lane Eligibility program. When the program shifted from an "opt-out" to an "opt-in" model, a significant number of families did not complete renewal paperwork and were disenrolled from the program. The state's ability to collect and analyze useful measures helped it to guide the priorities of its quality improvement agenda. Louisiana was among the first Maximizing Enrollment states to focus on data on cases that were closed for procedural reasons (like incomplete or missing paperwork) as a way to identify policy changes that could improve retention of eligible individuals.

Based on their work with Maximizing Enrollment states on data analysis, the Mathematica evaluation team developed a proposed set of 14 streamlined denial and disenrollment reason codes that are displayed in Figure 3.

Figure 3. Streamlined Denial and Disenrollment Reason Codes

Group One: Reasons That Establish Ineligibility		Group Two: Reasons Not Related to Eligibility	Group Three: Eligibility Cannot be Established
Death of applicant/enrollee	Time-limited eligibility period ended	Declined enrollment, or requested disenrollment	Lost to follow-up, unable to locate
Age outside program range	Residency criteria not met	Failed to make required premium payment	Missing forms, verification, or other information
Does not meet citizenship requirements	Requirements related to other health insurance not met		
Income, assets, earnings do not meet program requirements	Medical health status/condition		
Household/family composition criteria not met	Other categorical eligibility criteria not met		

Source: M. Harrington, C. Trenholm, A. Snyder, "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance," (Washington, DC: National Academy for State Health Policy, 2012).

Other Maximizing Enrollment states also focused on improving their tracking of disenrollment and denial reason codes as a way to identify places where individuals were losing coverage:

- *Closure Reports*: In Utah, the state identified that eRep closure codes made it difficult to understand why cases were closed or applications were denied. In response, the state developed new Medical Closure and Denial Reports that will enable the state to better identify these issues.
- *Using Reason Codes to Identify Enrollment Barriers*: Massachusetts was concerned that it was losing eligible individuals at renewal, so it worked to understand more about who was being disenrolled from the program and why. After analyzing case closures by reason code, officials determined that many disenrollments were due to missing paperwork. One cause of these closures was missing Job Update Forms. The state required MassHealth members to complete this paper form to verify state wage and new-hire information received on a data match from the state Department of Revenue (DOR). The state found that the use of job update forms created a significant barrier to coverage. In FY 2010, use of the form resulted in the disenrollment of almost 90,000 beneficiaries, or 46 percent of the 192,000 individuals who received these forms. Ninety-five percent of these disenrolled beneficiaries lost coverage solely because they failed to return job update forms or failed to complete these forms properly, and not because of a change in their eligibility status. The state also found that 38 percent of MassHealth beneficiaries who received job update forms retained eligibility for coverage, with almost 70 percent of these beneficiaries retaining eligibility with no change in their level of benefits. Moreover, using job update forms increased administrative work for MassHealth staff, including the work of processing the forms (more than 90,000 were

processed in FY 2010), increased call center volume due to questions about the job update forms, and responding to inquiries from advocates who help beneficiaries complete these forms.[21] As a result of their data analysis, Massachusetts implemented a more targeted job update process that now sends the form to a smaller subset of individuals, where there are differences in wage or employment data that would affect eligibility for benefits.

Dedicate Data Analysis Staff: At least two states, Utah and Virginia, found a benefit in having dedicated analysts to assist in analyzing enrollment and retention data and used grant funds to support that outcome. Devoting staff resources to data analysis increased the state leaders' capacity to ask for the data that they needed, and to better understand and act on data that their staff were collecting. This became clear to the Virginia state team when they worked with Mathematica to develop reports on enrollment trends at the county level. Rebecca Mendoza from Virginia noted the importance of staff who understood both the technical requirements to generate reports, and the programmatic knowledge to understand whether the reports were returning useful information. "If you don't know the background of the program enough, then you can make an incorrect interpretation. The data validation process is very critical. You have to have dedicated program folks to work on the reports as well as the technical folks" said Mendoza.

The difficulty of collecting data (and particularly data that are comparable across states) can be compounded if a state is dealing with a "legacy" computer system, where data elements may have initially been coded decades ago, in response to circumstances—like the pre-welfare-reform linkage between cash assistance and medical assistance—that are no longer in effect. As a result, data gathered from legacy systems can require very specialized knowledge to interpret. While most states have recently taken advantage of the availability of enhanced federal funds to replace legacy systems with modern eligibility information technology systems, these new systems will invariably gain complexities and quirks of their own. Devoting staff resources to data analysis may help states implementing ACA requirements to maintain a focus on IT systems that are streamlined enough to easily produce data that are reliable and understandable by staff at all levels of the organization.

Collect Data on Consumer Experience: In addition to data on entrances and exits from coverage programs, several Maximizing Enrollment states also worked to capture information about customer contacts with state programs. The metrics they developed were often tied to adoption of new technologies, some of which are described in greater detail in *Harnessing Technology to Streamline Enrollment: Experience from Eight Maximizing Enrollment Grantee States.*[22] Alabama, for example, found that tracking the time necessary to process an application to completion became much more easy and standardized after the adoption of electronic data management tools. Virginia developed reports showing which method applicants were using to apply for coverage – online applications, paper applications and phone applications. States also collected data on usage of telephone and online contacts by consumers, including measures of the volume of phone calls and electronic chats, wait times and abandonment rates.

Some Maximizing Enrollment states also found value in using focus groups as a means of gathering data on the consumer experience. In 2010, three Maximizing Enrollment states conducted focus groups with consumers to learn about their experiences with enrollment systems, and better understand their preferences for application modalities. Utah conducted eight focus groups and a survey of about 100 clients, and found that a majority preferred online applications, and contact through e-mail which informed the state's use of e-mail to prompt clients to log on to their secure

accounts to view important notifications. Louisiana and Alabama also held focus groups with parents of children who were either current enrollees, or whose enrollment had lapsed. Both states were able to gain information about how the families experienced the program, and where they experienced difficulty navigating enrollment and renewal. The focus groups highlighted that it was often difficult for families to monitor when a child was due for renewal, particularly if notices from the Medicaid or CHIP programs were difficult to read.

Monitoring data on user experience will be very important for all states in ACA implementation. Program metrics can help states track the extent to which new applicants are using paper, telephone, in-person or online application methods; determine whether newly eligible individuals are able to successfully complete the application process; identify areas where additional resources may need to be devoted to application assistance; and determine the effects that added caseload is having on state programs' administrative capacity.

Using Data to Drive Streamlining Policy Changes

Several Maximizing Enrollment states used their analytic reports to identify process simplifications specifically targeted to sub-populations of program enrollees. Below are two strategies states used:

Continuous Renewals: Some Maximizing Enrollment states' analysis of their data highlighted that certain vulnerable Medicaid enrollees had stable sources of income that did not change from year to year, resulting in ongoing continuous enrollment over time. Wisconsin, Massachusetts and Louisiana each used historical data about the stability of eligibility of certain enrollee groups to identify individuals who were likely to remain eligible without change. The states created an "administrative renewal" or "continuous renewal" process to renew eligibility without requiring affirmative renewals by the individuals enrolled. In most states, individuals who are identified as candidates for continuous renewal will receive a notice that they will be renewed automatically and are notified annually to contact the state if any changes in income warrant a change in their eligibility status.

Continuous renewal has reduced burdens both for states and for the populations selected for participation. Louisiana was an early adopter of continuous renewals. By the end of 2010, Louisiana had processed administrative renewals for 288,000 cases, equivalent to the workload of 160 full-time employees and generating a savings of $8.25 million annually.[23] Massachusetts uses continuous renewal for approximately four hundred disabled children in the state's Kaileigh Mulligan (Katie Beckett) program, and for almost 80,000 long term care members, community elders, members receiving Home and Community-Based Waiver Services, Medicare Savings members, and persons with disabilities whose sole source of income is Social Security and who are receiving Medicare. Wisconsin piloted continuous renewal with five groups, including certain elders and persons with disabilities, and also some family planning waiver enrollees, and members of families with incomes less than 75% of the federal poverty level (FPL). In Wisconsin's process, the CARES Worker Web automatically selects cases for renewal, determines eligibility, and generates a notice to the enrollee, without any intervention from an eligibility worker. Between May 2011 and April 2012, over 23,000 cases were renewed administratively, though the state is not currently planning to expand its use beyond those pilot groups.

Newborn Enrollment: Data analysis helped Virginia identify timeliness as an issue in enrolling "deemed" newborns (newborns who are considered to be eligible for Medicaid, provided that their mothers were Medicaid-enrolled on the date of delivery). There was an observable gap in coverage between the notification to the state of the birth, and the assignment of a Medicaid identification number to the newborn. Based in part on a strategy adopted by Oklahoma, Virginia implemented a pilot project with several hospitals to establish a direct connection between the hospital and the state that will automatically enroll these newborns and eliminate the coverage gap. The state plans to expand this pilot statewide.

Enhance Use of External Data Sources: Grantee states also worked to utilize data collected outside of their Medicaid and CHIP programs in order to better understand the characteristics of the clients they serve. Some of this work built on lessons learned from CHIP outreach efforts in using population-based surveys like the National Health Interview Survey or National Survey of Children's Health to learn about characteristics of uninsured children. Groups like Enroll America are also starting to use population specific information on uninsurance to micro-target ACA-related outreach to uninsured individuals. Other states may want to consider using available data sources as they work to understand the impact of ACA coverage options for uninsured populations in their state. Examples of Maximizing Enrollment state work in this area included:

- *State Data Sources*: Wisconsin pursued enhancements to the Wisconsin Family Health Survey, a statewide random telephone survey on health status, insurance coverage, and use of services.[24] The state worked with the University of Wisconsin's survey center on a specialized phone survey that probed for characteristics of uninsured children and adults. While the pilot's sample size was too small to draw definite conclusions, the effort informed the design of future survey instruments.
- *National Data Sources*: Virginia uses data from the American Community Survey to identify counties with high concentrations of the uninsured, and to focus outreach and enrollment strategies in those areas. With support from RWJF, the state worked with researchers at the Urban Institute to identify two counties with particularly high rates of uninsurance among teens. The state also worked with school districts and school nurses in those counties on targeted outreach strategies, including the launch in November 2011 of the first annual Teen Health Week.

States looking to maximize their capacity to use and understand state and national surveys may also want to consult additional resources, including those available from SHADAC.

Moving forward, state and federal programs may also want to pay special attention to tracking the movement of individuals between programs through both internal and external data sources. Each transfer between Medicaid, CHIP, marketplaces and employer-sponsored coverage presents the risk for a disruption in coverage, due to missed deadlines, incomplete applications, or missed hand-offs between programs. Disruptions in coverage can lead to increased health costs due to delayed receipt of care, and increased costs in time and manpower due to reprocessing applications. This is of particular concern in states where multiple state and local agencies (and now, in many states, health insurance marketplaces operated by the federal government) have a role in eligibility and enrollment processes. Common, transparent measurement methods can support coordination across agencies and programs and can also support buy-in among local agencies to new policies and procedures to address issues that arise.

Coordinating Across Programs and Agencies

Building and maintaining effective connections, both within and across offices, agencies and programs is a critical thread that helps to pull the fabric of the change management tapestry tightly together. While sound coordination among programs and agencies is clearly needed in states with integrated health and human services eligibility systems, it is equally important for states that operate independently-run health and human services programs. Maximizing Enrollment state experience demonstrated the value and importance of effective coordination, both across programs and agencies and between state and local-level operations. This was true, despite the differences in the state's health coverage and other program structures. For states like Virginia and Illinois that operate eligibility systems that coordinate enrollment processes across health and human services agencies and programs, implementing even a single policy change can require involvement, commitment and

support from multiple agencies. Similarly, Massachusetts, which operates all of its health programs through a central agency, MassHealth, and delinked health and human services operations a number of years ago, still needs to coordinate across multiple health coverage programs to ensure families are enrolled in the right program. This need for coordination among all health coverage programs will increase for all states as the ACA is implemented. In addition, the states that use local or county offices to administer eligibility face additional coordination challenges arising from the number and diversity of offices to work with to implement and sustain change. For all of these reasons, coordination was a critical component in managing change for Maximizing Enrollment states and will continue to be an area of focus for these and other states as they implement the ACA's requirements. Some experiences and models for effective coordination, both across agencies and between state and local entities are offered here:

Collaborate and Integrate Across Agencies and Programs: For most of the Maximizing Enrollment states collaboration, coordination or even integration with multiple programs, was an important component of their grant work. Collaboration across agencies and programs entailed different elements in different states, and was expressed in communication structures, shared staff and other resources, system integration, or sharing data. A common critical success factor among Maximizing Enrollment states was prioritizing clear and consistent communication among different parties. States also found importance in investing in a structure and method for decision-making, especially among co-equal programs or agencies. Specific examples of agency and program coordination in Maximizing Enrollment states include:

Creating Workgroups with Health and Human Service Program Representation: Maximizing Enrollment supported both Virginia and Illinois' efforts to further improve the coordination between the states' Medicaid and CHIP programs and their human services agency. In Virginia and Illinois, the Medicaid agencies work very closely with the departments responsible for the states' human services programs as both have oversight responsibilities for eligibility determinations for both human service and health programs. To improve coordination on grant initiatives, both Illinois and Virginia included representation from both health and human services state agencies on their Maximizing Enrollment teams. Participation in these teams helped to create a space for regular communication that served to keep both agencies updated on enrollment activities and helped to identify issues and solutions. For instance, in Illinois the Department of Human Services (DHS), the agency responsible for eligibility systems for Medicaid, SNAP, TANF, and other means-tested programs, and the Department of Healthcare and Family Services (HFS), the agency responsible for Medicaid and CHIP policy and CHIP eligibility determinations, worked together to design the first coordinated, comprehensive training project that is used for eligibility staff in both agencies. Because both agencies' staff make eligibility determinations, administrators wanted to use a common training protocol to ensure consistent processes and information presented to and available for staff, regardless of the department that supervises them. Illinois reported that eligibility system processing accuracy and efficiency improved for both agencies as a result of the training.

Integrated Technology and Shared Resources: Utah implemented a fully integrated electronic eligibility system shared among health and human service programs, including Medicaid, CHIP, SNAP, TANF and others, during the course of Maximizing Enrollment, modeling how sister agencies can share IT systems and resources to improve coordination. Utah's Department of Health (DOH) oversees Medicaid and CHIP policy and operation and the Department of Workforce Services (DWS) oversees the state's human service programs and health and human service program eligibility determinations, including for Medicaid and, also more recently, for CHIP, so the two departments need to coordinate around all eligibility, enrollment or renewal changes. In 2009, Utah began designing and rolling out its rules-based eligibility system, called eRep. ERep's updated platform and nimble design has allowed the state to make ongoing enhancements to electronically verify application information and support online consumer accounts.[25] State officials report that these

technology advancements allow eligibility workers to be more efficient and increase accuracy. Collaboration by both departments to design the system to meet both health and human services programs' needs and coordinated support of the staff as this change occurred was as critical as the technology.

Communicating Clearly and Frequently About Change: Massachusetts offers another example of coordinating across programs as a result of its 2006 state health reform initiative through which the Health Connector was created. The Massachusetts Health Connector is essentially the country's first state health insurance exchange; it allows individuals and small businesses in Massachusetts to purchase health insurance. In addition to establishing the Connector, the Massachusetts health reform law also established Commonwealth Care, subsidized health coverage for adults with incomes up to 300% of the (FPL) who are not otherwise eligible for Medicaid.[26] Existing MassHealth, the state Medicaid agency, systems and program standards served as the foundation for these reforms. To implement new coverage options, officials from MassHealth and the Connector, a quasi-government, non-profit organization, began working together, sharing system resources and meeting regularly to establish a transparent governance structure. A working group was established to make decisions about what entity would perform what functions. As a part of this work, a number of process flows mapping out the steps from application to enrollment for consumers were drafted and redrafted to ensure a "no wrong door" approach. The coordination between the programs continues as the state prepares to implement the ACA, and the administrators and staff draw on lessons from their prior collaboration beginning in 2006. Both MassHealth and Connector officials agreed that building a coordinated, seamless coverage system requires frequent communication and establishment of a common language to address issues, since there can be differences in how terms are used in different agencies.

Coordinate Between State and Local Offices: Six of the Maximizing Enrollment states—Alabama, Illinois, New York, Utah, Virginia and Wisconsin—divide responsibilities for their Medicaid program between state and local levels. In each of the six states, a central Medicaid office sets policy for the program and works with the Centers for Medicare and Medicaid Services (CMS), while local offices have responsibilities for making eligibility determinations and providing case management. In these states, and most others across the country, county or local offices fall under the jurisdiction of a different department or agency from the central Medicaid office and these local entities may be independent county offices or part of a state agency. Local entities have varying types and degrees of accountability depending on their relationship with the state – some local workers are state staff, while others are county staff that works within a contract or agreement with the state to provide eligibility services. Typically, the local or county offices are responsible for multiple means-tested human service programs that families depend on including: SNAP, TANF, Low Income Home Energy Assistance Program (LIHEAP), and childcare subsidies. While arrangements differ depending on the state, in most cases local office staff is managed by either the county or the agency responsible for the human service programs and not by the Medicaid agency. The state Medicaid agency contracts with the oversight human services agency and provides funding support for local agency staff to make Medicaid eligibility determinations in addition to those made for the other social service programs. The benefit of these arrangements is that a family can apply for all of the public programs for which they may be eligible at one office. However, coordinating the eligibility and enrollment policies, procedures and systems can present challenges.

Barriers to coordination between state and local operations can include the absence of a unified IT system, difference in performance and caseload volume and the absence of a common structure or department supervising local office work. Considering the existing coordination challenges, some states have considered separating health from the integrated human service program eligibility determinations at the local level, especially as exchanges are implemented. The ACA requires that the exchange, Medicaid and CHIP eligibility systems closely coordinate to support seamless data

transfers. The ACA vision for seamless data transfers does not easily accommodate a health insurance exchange sharing data with multiple local offices. Due to the challenges of sharing data across multiple offices, many states are, at least initially, integrating eligibility systems for health coverage separate and apart from human services. The Maximizing Enrollment states are taking different approaches. For instance, Alabama is building a new eligibility system integrating Medicaid and CHIP that will coordinate with the federally facilitated exchange, but initially the system will not integrate with human service programs, although the state is planning future integration. Illinois and Virginia are planning to maintain integrated eligibility across health and human services programs; local offices eligibility systems will connect with a centralized state system that will be the single data exchange point for the exchange, which, at this point, is the federally facilitated marketplace. New York and Wisconsin instead opted to redesign state and local office Medicaid responsibilities and began implementing changes during the Maximizing Enrollment initiative. Their experiences serve as two alternate models in structuring state and local operations as programs evolve.

Leveraged Local Resources: Illinois is planning to maintain its local eligibility offices and is building a new and improved eligibility system to facilitate coordination of enrollment data received across the state into one centralized system that connects with the federally facilitated marketplace. State officials have acknowledged that staff roles and responsibilities will likely need to change to meet the demands of the ACA health coverage environment. Health and human service program representatives meet regularly to discuss changes to systems, policies and processes to support the state's 'No Wrong Door' approach to ACA implementation. One example of the state's coordination efforts was showcased early in the ACA's health insurance exchange open enrollment period, which began in October 2013, when Illinois routed consumer calls coming into the state's call center to local eligibility staff. Illinois used available data to try to predict call volume that would come to its call center during open enrollment, but found the volume higher than anticipated. As a way to minimize the hold times consumers were experiencing, the state began routing some calls to local office staff. An Illinois state official shared that shifting the workload from the call center to local offices that were experiencing less demand, served both the staff and consumers well.

Centralized Medicaid Administration: During the course of the Maximizing Enrollment grant period, New York has undertaken a major redesign of its state and local office operations, including piloting a centralized approach to some eligibility functions. In June 2010, New York's legislature enacted legislation requiring the Department of Health (DOH), the state agency responsible for the Medicaid program, to assume administrative responsibilities for Medicaid from 58 counties within five years. New York's counties are currently authorized to determine eligibility for Medicaid and other human service programs as well as provide case management support.[27] New York's counties vary substantially in population, size and culture. State officials reported that in centralizing Medicaid administration, they are seeking to improve efficiency and reduce costs while ensuring consistency in administrative processes and decision-making.

In developing its plan for centralization of county functions, New York's DOH first reviewed county roles and functions to determine which functions were intrinsically local and which could benefit from economies of scale and were transferrable to state operations. Their report, reviewing functions, operations and laying out options, are a useful resource for other states considering the roles and options for state and local management of Medicaid functions.[28] The report's findings were discussed and debated among state leaders, and the DOH ultimately adopted a phased approach including establishing a consolidated "Customer Service Center" that, when fully implemented, will be staffed by both public and private vendor employees, drawing experienced staff from counties. The DOH's first step in creating this Center was the establishment of an Enrollment Center that was responsible for some Medicaid renewals in counties outside New York City beginning in 2011 with Maximizing Enrollment support. In 2014, the state is rolling out a statewide Customer Service Center responsible for conducting all of the state's modified adjusted gross income (MAGI) eligibility determinations. The

counties will continue to conduct non-MAGI determinations and may identify non-MAGI populations that they want to continue to administer to in future years under contract with the state over the long-term such as chronic care eligibility. By April 2018, the statewide Customer Service Center is expected to conduct all eligibility determinations with the exception of those retained by the counties under mutual agreement between the DOH and the county.

Through the process to centralize more of the administrative responsibilities from the counties, New York learned lessons that may be helpful to other states considering similar changes. Although the state was building new tools to gain efficiencies in renewing individuals' coverage, there were some bumps along the way. When the Enrollment Center began conducting Medicaid renewals for several counties in 2011, their work coincided with the launch of a new systems tool to facilitate telephone renewals. The new tool – Healthcare Eligibility and Renewal Tool (known as HEART) was designed specifically for the Enrollment Center to streamline telephone renewals. The state requested that counties volunteer to help pilot the centralized Medicaid renewals and the response was mixed. Some county offices, struggling with limited resources and increased demand for services, were eager to shift Medicaid renewal responsibilities to the Enrollment Center, but other counties were hesitant. The Enrollment Center piloted HEART with counties that volunteered, and there were initial challenges. HEART wasn't fully compatible with the state's legacy Medicaid system and this incompatability resulted in errors that required significant recoding before the Enrollment Center could take over additional counties' renewals. Despite a bumpy start, the centralized processing worked much better once the technology was fixed - in 2013, the Enrollment Center was successfully processing renewals for 35 counties outside New York City, representing over 25,000 renewals a month. DOH officials report that centralizing renewals in a phased approach that allowed for testing served them well in developing a new eligibility system that integrates Medicaid, CHIP and the state's marketplace. However, the initial technical glitches did slow down the transition of administrative responsibilities from the counties to the state, and undermined counties' initial confidence in the partnership. States seeking to replicate an approach to centralization may want to pilot new approaches before building statewide capacity and also ensure their technology can support new functions before taking on too much operational control to minimize system impact in the first phase.

County Consortium Model: Wisconsin implemented a county consortium approach to address the variability in timeliness, accuracy in processing, and workload variations and backlogs for Medicaid applications and renewals across Wisconsin's 72 counties. The state sought to consolidate the county infrastructure to increase coordination of program resources and streamline processes. Unlike New York, Wisconsin chose to create a consortium model to consolidate authority over county offices, not to centralize functions.

In January 2012, Wisconsin began to transition Medicaid administrative responsibilities from 72 counties to 12 Income Maintenance (IM) agencies comprised of 10 regional consortia, Milwaukee County (the largest county in the state) and one Native American Tribe. The Consortia continue to have administrative responsibilities for health and multiple human service programs and use ACCESS, Wisconsin's single online application portal for multiple programs, to support integrated eligibility but across 12 agencies rather than 72. The simplified structure is intended to increase coordination across the state through transparent and consistent processes.

Because the consortia model removed some of the prior geographic boundaries among local offices, state officials now report it is easier for offices to share work across county lines and consumers can go to any local office within the consortia, which are all within one IM agency. The transition took time, required the state and the consortia to work through system and process changes, and was still new in 2013, but state administrators report there has been progress made toward early goals.[29] These goals include:

- Reach an economy of scale amid the economic pressure to do more with less;
- Maintain a local presence; and
- Enhance the availability of phone and online services.

In addition to increased state and county communication, these changes have also coincided with improvements in retention among Medicaid beneficiaries.

Lessons for Other States

The transformations that the Affordable Care Act (ACA) requires have big implications for how states set their policy priorities, coordinate their work across agencies and programs, and measure their progress. By looking across the many threads of programmatic change that Maximizing Enrollment grantee states pursued, several key lessons emerge that may offer value to other states in the midst of ACA implementation.

Leadership Can Prioritize Resources: High-level leadership from the Governor's Office or from a Cabinet Secretary is essential to achieving programmatic change. The Administration is charged with setting the vision for the state and, in doing so, prioritizes state resources to support efforts to achieve it. During the Maximizing Enrollment initiative, state administration priorities were reflected in program budgets, leadership commitment and staffing. Some of the Maximizing Enrollment states had continuity in vision and goals for their program despite leadership change, which helped sustain progress, while in other states, differences in priorities of a new administration had an effect on the degree and nature of state participation and work towards program goals.

Establish Shared Goals: Identifying existing or establishing new goals for the programs (i.e. Medicaid and a separate Children's Health Insurance Program (CHIP) or offices serving the program (i.e. Medicaid's central office and the local eligibility offices) provides a foundation for initial and ongoing engagement. While leadership from the Governor, Secretary or agency director can set the vision, bringing together agency staff at different levels to create goals to meet that vision establishes a collaborative environment. Initial agreement in identifying interim and achievable milestones is critical to short- and long-term success in reaching the overall vision. However, it is also important to maintain some flexibility to shift interim priorities in a changing environment. The Maximizing Enrollment states found that focusing initial discussions on finding ways to increase efficiency for offices and workers helped to engage all parties.

Institute Regular Communication: While states can make progress through work together on an initiative, institutionalizing structural partnerships between programs and agencies is necessary to maintain and build on gains. One way to ensure agency partnerships are sustained is to create a communication infrastructure that does not depend on an individual staff person or relationships. Several grantee states created work groups that include representatives from multiple agencies or across programs to work together toward group identified goals throughout the project period. Although the program is winding down, states are continuing these work groups as a way to maintain institutional knowledge and leverage expertise for new projects and future system improvements. In addition, states found value in establishing a process for sharing that information across offices and with staff at all levels on an ongoing basis. This communication could be done through electronic means, such as web trainings or using an agency wide intranet, or by holding in person meetings.

Design Systems to Capture Usable Data: Data that can meaningfully inform states' decisions don't just magically appear. Developing, validating and reporting on measures require the dedication of time, staff, and resources. But the opportunity presented by states' overhauling their decades-old eligibility systems to comply with the ACA suggests that it is worth the investment of resources for

states to build in data collection systems that will help them respond to questions they are facing now and into the future. In some cases, this can mean collecting *less* information. Several Maximizing Enrollment states maintained literally hundreds of disenrollment codes—far too many to be useful for setting policies. Rather than just having a new system collect all the cluttered information that the old system did, states can focus their data collection on a few key indicators that are precise enough to be understandable, but general enough to be actionable.

Exploit All Your Information Systems: Maximizing Enrollment states thought broadly about where they obtained information about their programs. They tracked data on enrollment and retention, and they also took advantage of the move from a paper-based to an electronic application system to develop a better understanding of application processing times and hang-ups in the determination process. Reports from call centers helped states understand the effect of changes like introduction of telephone renewals, and customer service needs of individuals completing online applications. States also looked beyond internal administrative data, to things like stakeholder meetings, enrollee satisfaction surveys and worker focus groups to get a variety of perspectives on which aspects of their programs were working, and which weren't.

Culture Change is Ongoing: At a Maximizing Enrollment state-to-state meeting in Louisiana, Ruth Kennedy, then the Louisiana CHIP director, defined agency culture change as "the way we do things around here." The technological and programmatic changes happening as a result of health reform present an opportunity for states to reorient how they do things—policies, procedures, and agency culture. States should take this opportunity to not fall into a new pattern of "things we do because that's what we do," but instead strive to maintain a focus on continuous improvement and remember to share changes and solicit ideas for a new way of doing things from multiple sources and stakeholders.

Future Directions

Building on the foundation states have developed through partnerships, improving the collection and analysis of data, with the support of leadership to pursue more seamless and efficient eligibility, enrollment and retention practices in coming years, there are a number of additional strategies states may wish to consider:

Integrating Health and Human Services Eligibility and Enrollment Systems: Families who access the full package of benefits for which they are eligible, including Medicaid, Children's Health Insurance Plan (CHIP), Supplemental Nutrition Assistance (SNAP), Temporary Assistance for Needy Families (TANF) and child care subsidies, experience better health and nutrition outcomes for children.[30, 31] Although human service benefit programs have different eligibility rules, some states have maintained integration across human service and health programs, also referred to as horizontal integration. States that aim to integrate by using one application for all health and human service programs, coordinating streamlined enrollment processes, and sharing data across programs, can ease the enrollment for families. Successful horizontal integration requires committed state leadership, partnerships across programs, reforming business processes and workflows, and a lot of coordination. Given the demands of implementing the Affordable Care Act (ACA), many state Medicaid, CHIP and health insurance marketplace programs have been focused on health programs only. Virginia and Illinois are maintaining their horizontal integration model while implementing health care reform, and six states (including Illinois) participating in Work Support Strategies are also planning for horizontal integration.[32] Other states may want to explore the opportunity to link multiple public benefit programs that serve the same low-income families, especially considering the available federal funds to support technology enhancements to eligibility systems. Some states may choose to

delink or separate their health and human service program eligibility systems, while ensuring ways to share data across programs to help families in need of multiple benefit programs.

Continuing to Redefine Roles of State and Local Agencies, and Community-Based Organizations: New technologies and new requirements under the ACA are prompting many states to reexamine how work on eligibility and enrollment is divided between state and local entities. Maximizing Enrollment states have only just started their efforts to develop a shared vision for whether existing structures should be maintained, and it will take several more years to fully work through all the issues related to how labor, responsibility and funding for eligibility and enrollment work should be allocated. Added to this, the ACA envisions a much more robust role for community-based organizations in providing application assistance to applicants. States like Massachusetts have some experience engaging with groups like community health centers, including providing enhanced access to eligibility information through its online application portal, the Virtual Gateway, but others may need to work closely with external stakeholders to develop this role.

Tracking Performance Across Programs: Much of Maximizing Enrollment states' work was focused at improving retention of individuals who stayed eligible for a single coverage program. It is well established that the population of poor and near-poor individuals targeted by the ACA's Medicaid expansion and premium tax credits have volatile incomes, and thus may transition frequently between Medicaid and Marketplace coverage. [33] States may wish to develop enrollee identifiers and measures of performance that look across Medicaid, CHIP and marketplace programs to get a complete picture of whether individuals are able to move seamlessly between programs, and where snags may be occurring. The strong initial role for the federally facilitated marketplaces in the launch of ACA's coverage provisions means that there will be a strong federal role in the development of any such measures, and suggests that states may want to work together, and with HHS, to develop a standard, coordinated way to collect transfer data.

Conclusion

The Maximizing Enrollment program coincided with a tumultuous five years for state health coverage programs. Even in the midst of major environmental changes—due to multiple factors, not the least of which was the enactment of the Affordable Care Act (ACA)—state leaders charted a course toward achieving their own goals for improving systems for enrollment and retention of eligible individuals. To support the accomplishment of meeting those goals, Maximizing Enrollment states created a tapestry of change management by: 1) securing committed leadership to set a clear vision and encourage a culture of coverage through engagement of program and non-governmental stakeholders; 2) improving the collection and analysis of data to make more informed programmatic decisions; and 3) coordinating across agencies and state and local levels to increase efficiencies and more effectively serve families.

The ACA brings new challenges and opportunities that demand a lot from states. Maximizing Enrollment states' lessons in managing programmatic change to support the state's vision for health coverage may be valuable as all states move forward with their implementation work. With commitment and attention to the values of leadership, data and coordination, states can use these threads to weave their own unique fabric for streamlined health coverage for their citizens.

Notes

[1] Jennifer Edwards et al., *Maximizing Enrollment for Kids: Results From a Diagnostic Assessment of Enrollment and Retention in Eight States* (Washington, DC: National Academy for State Health Policy and The Robert Wood Johnson Foundation, 2010).
[2] Express Lane Eligibility (ELE) allows states to rely on either components or entire eligibility determinations of other human service programs to determine eligibility for Medicaid and CHIP. States can use information that has already been provided by low income individuals applying for SNAP, TANF, and other programs not only to identify individuals already in the system, but also to reduce the documentation burden on both the families and the state.
[3] Although the authorization for ELE is due to expire in September 2014, Massachusetts' waiver grants the state's ELE approval to include language that the state intends to use ELE as part of its ACA enrollment strategy.
[4] Uchenna Ukaegbu and Sonya Schwartz, *Seven Steps Toward State Success in Covering Children Continuously* (Washington, DC: National Academy for State Health Policy, 2006).
[5] Ibid.
[6] Governor Rod Blagojevich left office on January 29, 2009 after the Illinois House of Representatives voted to impeach him and the State Senate voted to remove him from office, and not as a result of an election.
[7] Governor Jon Huntsman was appointed the United States Ambassador to China, resigning as Utah's Governor on August 11, 2009. Lieutenant Governor Gary Herbert assumed the office when Governor Huntsman left office and won a special election in 2010 to serve out the remaining term. In the 2012 elections, Governor Herbert won a full, four-year term.
[8] State officials from many states have shared during in-person meetings, conference calls and through discussions on statereforum.org (https://www.statereforum.org/exchange-governance) how their health insurance exchanges' governance structure has been formed and spoke of the value of varied perspectives.
[9] Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Washington, DC: Maximizing Enrollment Program, 2009).
[10] For more information on Robert Wood Johnson Foundation's *Covering Kids and Families* initiative, please visit: www.coveringkidsandfamilies.org.
[11] Alabama has approval to use ELE to enroll and renew children in Medicaid if they are active in SNAP. Also, through a waiver the state has authority to enroll and renew women ages 19 to 55 years old in the family panning program if they are enrolled in SNAP.
[12] Manatt, *Simplified, Real-Time Verification Issue Brief* (Washington, DC: Medicaid and CHIP Learning Collaboratives, 2013).
[13] Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children*
[14] Alice Weiss and Katie Baudouin, *Harnessing Technology to Streamline Enrollment: Experience From Eight Maximizing Enrollment Grantee States* (Washington, DC: Maximizing Enrollment Program, 2013).
[15] Christopher Trenholm and Mary Harrington. PowerPoint Presentation. "Using State Enrollment Data to Sustain and Improve Programs." Presented at the Maximizing Enrollment Fourth Annual Grantee Meeting, Maximizing Enrollment Program, Washington, DC, January 9, 2013.
[16] Maximizing Enrollment. "An Interactive Diagnostic Toolkit to Help States Improve Enrollment and Retention of Children in Medicaid and CHIP." Retrieved November 25, 2013. http://www.maxenroll.org/page/self-assessment-toolkit.
[17] Christopher Trenholm et al., *Using Data to Drive State Improvement in Enrollment and Retention Performance* (Washington, DC: Maximizing Enrollment Program, 2011).
[18] Mary Harrington, Christopher Trenholm, and Andrew Snyder, *New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance* (Washington, DC: Maximizing Enrollment Program, 2012).
[19] Centers for Medicare & Medicaid Services. "Data Analytics to Support Program Operations." Retrieved November 25, 2013. http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Data-Analytics.html.
[20] Centers for Medicare & Medicaid Services, *Request for Information: Performance Indicators for Medicaid and Children's Health Insurance Program (CHIP) Business Functions: Solicitation of Public Input* (Baltimore, MD: Centers for Medicare & Medicaid Services, 2013).
[21] Maximizing Enrollment Minute, *Cutting Red Tape to Keep Eligible Families Enrolled in Massachusetts* (Washington, DC: Maximizing Enrollment Program, 2010).
[22] Alice Weiss and Katie Baudouin, *Harnessing Technology to Streamline Enrollment: Experience From Eight Maximizing Enrollment Grantee States*
[23] Maximizing Enrollment. PowerPoint Presentation. "Improving Eligibility and Enrollment: Models for Health Reform Implementation." Presented at the Western Regional Call, Maximizing Enrollment, Washington, DC: February 24, 2011.
[24] Wisconsin Department Of Health Services. "Family Health Survey." Retrieved November 25, 2013. http://www.dhs.wisconsin.gov/stats/familyhealthsurvey.htm.
[25] Alice Weiss and Katie Baudouin, *Harnessing Technology to Streamline Enrollment: Experience from Eight Maximizing Enrollment Grantee States*
[26] Kaitlyn Kenney, Stephanie Chrobak, and Kerry Connolly. PowerPoint Presentation. "Exchange Experience: The Massachusetts Health Connector." Presented at the Massachusetts State to State Exchange, Maximizing Enrollment, Boston, MA, March 24, 2011.
[27] New York State Laws of 2010, Chapter 58, § 47-b.
[28] State of New York Department of Health, *New York State Medicaid Administration November 2010 Report* (Albany, NY: State of New York Department of Health, 2010).
[29] Sabrina Fox, Meeting Notes. Presentation at Wisconsin's 2012 Site Visit, Maximizing Enrollment, Madison, WI, April 12, 2012.
[30] Gregory Mills, Jessica Compton, and Olivia Golden, *Assessing the Evidence About Work Support Benefits and Low-Income Families* (Washington, DC: The Urban Institute, 2011).
[31] Olivia Golden, *Early Lessons From the Work Support Strategies Initiative: Planning and Piloting Health and Human Services Integration in Nine States* (Washington, DC: Work Support Strategies Program, 2013).
[32] Work Support Strategies: Streamlining Access, Strengthening Families provides a select group of states with the opportunity to design, test, and implement more effective, streamlined, and integrated approaches to delivering key supports for low-income working families, including health coverage, nutrition benefits, and child care subsidies. For more information on this initiative, please visit: http://www.urban.org/worksupport/.
[33] Benjamin D. Sommers and Sara Rosenbaum. "Issues of Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011 30(2): 228-36.