



## ELIGIBILITY AND ENROLLMENT – DRAFT INTERIM FINDINGS

Submitted to Maryland's Health Care Reform Coordinating Council

Entry to Coverage Workgroup – 31 August 2010

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### INTRODUCTION

Established in 2006, the *Maryland Women's Coalition on Health Care Reform* is a statewide alliance of individuals and 53 women's organization working to ensure that every Marylander has access to comprehensive, affordable, accessible, and high quality health care.

Included among the strategies to address this, the Coalition undertook an analysis of the eligibility and enrollment policies and procedures for public health programs within the Department of Health and Mental Hygiene (DHMH) and Local Health Departments (LHD). The impetus for this was a comment made by DHMH staff that there are "24 ways to do eligibility and enrollment in Maryland." To inform our analysis the Coalition had on-site and/or tele-conferences with 15 of the state's 24 LHDs<sup>1</sup> - from the smallest counties, Kent<sup>2</sup>, to the largest, Montgomery<sup>3</sup>.

Because the task of this workgroup focuses on entry to coverage, the following relates to this specific area. However, that is but one element of what the Coalition believes should be the over-arching goal of implementation of PPACA – a fully integrated health

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<sup>1</sup> The counties contacted include: Allegany, Anne Arundel, Baltimore City, Baltimore County, Calvert, Caroline, Cecil, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, and Talbot

<sup>2</sup> 2010 projected population – 20,300

<sup>3</sup> 2010 projected population – 966,000

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care system. Therefore, the Coalition will submit a fuller account of our initial findings as part of further testimony for other Health Care Reform Coordinating Council Workgroups.

It should be said at the outset that both DHMH and the Local Health Departments are staffed by dedicated professionals who are committed to enrolling eligible residents in a timely manner and to ensuring that they get the care they need. However, today they face a diverse set of barriers. Among the principal issues are:

- **Maryland’s antiquated IT systems.** These have been “patched” over the years using, as one LHD staff member said, the “fire fighting approach” to tamp down flying sparks without addressing the underlying fire. What has been created are *islands of automation* that inhibit essential cross-program communication and undermine the state’s efforts to identify and enroll those eligible for public programs and to do timely redeterminations. Among other adverse effects of the present IT systems are delays in the delivery of services and the tracking and reporting of public health data.
  - DHMH is to be congratulated for gaining the grant to develop Health-E-Maryland. This program is a significant advancement to ensure entry to coverage for all those who are eligible. But in many ways it is yet another patch, in part because it does not communicate with the CARES entry to coverage system.
- The **lack of sufficient staff** that includes everything from outstation workers to IT support staff at individual LHDs

Therefore, despite the best intentions of departmental staff, legislators and others – the **basic system is broken and decidedly inadequate for full implementation of PPACA.**

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This may sound like bad news, but in fact it provides the state with a unique opportunity – albeit a challenging one – to create a new and more effective system. And, it could do this in a way that, as one health officer put it, is long overdue – comprehensive strategic planning to create fully integrated systems across departments backed by policies that ensure equality in eligibility determinations and the resources to ensure long-term sustainability of the systems.

## RECOMMENDATIONS

Presented below are the Coalition's recommendations to the Entry to Coverage Workgroup on the initial steps that should be taken to improve the landscape for eligibility and enrollment practices for public health programs.

1. **Create a 21<sup>st</sup> century IT system that is integrated and interoperable between, and among, DHMH, DHR, DSS and the local health departments.**
  - a. **Every state system that supports enrollment (Health-E-Maryland, SAIL, MMIS, CARES and MABS) must use common standards** – same technology, database structure, interface mechanisms, programming languages, etc. And, these must comply with MITA standards established by CMS.
    - i. In support of this, a 2005 GAO study on participation in means-tested programs recommended data sharing between agencies and offices, better information technology, and use of technological innovations as key steps to improve participation rates in means-tested programs.<sup>4</sup>
  - b. This is essential if Maryland is to create the **“no wrong door”** process that will guarantee that any point of entry is the right one. And, as part of this, to implement a **“one stop shop”** approach where families can access multiple programs with a single application. The Coalition fully supports these two approaches and Health-E-Maryland has many of the features that would enable their implementation.

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<sup>4</sup> *Helping Americans Help Themselves*: Thomas Z. Freedman and Michael Weinstein, March 2010. [www.dlc.org/documents/singlestop.pdf](http://www.dlc.org/documents/singlestop.pdf)

- c. To create such a system, as noted above, will require a **comprehensive and inclusive strategic planning process** with the full commitment and involvement of all relevant state agencies, LHDs, community based groups and others. The Council may wish to consider whether the success of such process would be enhanced by oversight from the State Department of Technology.
  - d. This project will only be successful if there is a commitment to provide **full funding and other resources** in the long-term to ensure that: systems are upgraded and sustainable; IT and enrollment staff have the appropriate expertise and training; and that included is a component for the collection and analysis of all relevant data.
2. **Improvements in communications between state agencies, LHDs and other organizations** involved in entry to coverage. Such improvements would include both web-based tools (webinars, etc.) tele-conferences, agency “help” desks and training programs.
  3. **Simplify all consumer communications tools** – including applications and redetermination letters. The latter, in particular, are so confusing that consumers often just give up rather than trying to re-enter the system.
    - a. On the **issue of re-enrollment**, Louisiana commissioned a Retention Analysis Report that could inform Maryland’s efforts in this area.<sup>5</sup>
  4. **Redesign and simplify the DHMH web portal**

In addition to the recommendations above that are based on the Coalition’s LHD meetings, we also propose for the Council’s consideration the following:

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<sup>5</sup> *Reducing the Number of Uninsured Children: Retention Analysis Report* Assessment Research Associates, Inc. [available through <http://www.dhh.louisiana.gov>

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1. There will be new challenges that arise with the expansion of Medicaid and the creation of the Exchanges, where consumers at the lower income levels will move between public and private programs. This process will need to be as seamless as possible. This could be achieved by putting all programs (private and public) within the Exchange. And, creating the same standards for eligibility across programs to expedite enrollment.
2. With passage of the Kids First Act and the subsequent Kids First Express Lane Eligibility Act in 2010, Maryland instituted an effective use of tax data to expedite the identification and enrollment of children eligible for MCHIP.<sup>6</sup> Now is the time to expand this to include all of the public health programs. As the Healthy Howard program demonstrated, there are a significant number of eligible but non-enrolled individuals and the use of tax data will enhance the entry to coverage. And, as Robert Nelb states in his paper, *Effortless Enrollment*, "... new data suggest that the tax system is the most effective way to reach eligible families."<sup>7</sup>
3. For the underserved and "hard to reach" communities, Maryland might consider locating outreach offices in locations where these individuals feel most comfortable. These could include enrollment stations at locations such as churches and schools, as well as at less "conventional" sites such as post offices.<sup>8</sup>

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<sup>6</sup> For analysis of the Kids First Act see two papers: (1) *Maryland: Using Tax Forms to Identify Eligible Kids*: Commonwealth Fund, August/September 2009

<http://www.commonwealthfund.org/Content/Newsletters/States-in-Action/2009/August/August-September-2009/Snapshots/Maryland-Using-Tax-Forms-to-Identify-Eligible-Kids.aspx> and (2) *Using Information from Income Tax Forms To Target Medicaid and CHIP Outreach: Preliminary Results from the Kids First Act*: State Health Access Reform Evaluation, September 2009

<http://www.shadac.org/files/shadac/publications/MarylandKidsFirstTaxForms.pdf>

<sup>7</sup> *Effortless Enrollment*: Robert Nelb, May 2009 <http://ccf.georgetown.edu/index/cms-file-system-action?file=research%2Foutreach%2Feffortless+enrollment.pdf>

<sup>8</sup> *Helping Americans Help Themselves: Toward a National Single Stop Policy*: Thomas Z. Freedman & Michael Weinstein. March 2010 <http://www.dlc.org/documents/SingleStop.pdf>

In summary, Maryland must seize this opportunity to ensure that entry to coverage is seamless and timely with policies, procedures and programs that are integrated across all departments. If we don't, we will be unable to take advantage of the multiple benefits of the new law for years to come. With new systems, our state will be better able to assure all Marylanders of the health care they need and deserve.