



Report

Integrating Health and Human Service Programs to Expand Eligibility

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With the passage of the Patient Protection and Affordable Care Act (ACA), millions of Americans were provided the opportunity to attain health insurance coverage.

Under the Act, households with incomes up to 400 percent of the federal poverty guidelines (FPG) are eligible for federal subsidies to help them afford health insurance premiums. The ACA also expanded Medicaid—at least in those states that chose to adopt the expansion—to cover adults and children with incomes at or below 138 percent of FPG, making millions of households newly eligible. (To date, [27 states and the District of Columbia](#) have expanded Medicaid). Enrollment for the first year of the ACA began October 1, 2013 and continued through March 31, 2014. Enrollment for the second year began November 15, 2014 and continues through February 15, 2015.

States may choose to set up and operate their own health insurance marketplaces, also called [exchanges](#), and enroll their citizens through their exchange website, phone centers and other methods. Thirteen states and the District of Columbia have chosen to do so. A few states partner with the federal government and conduct some enrollment functions, but mostly rely on the federal government exchange. In the remaining states, the marketplace is federally-facilitated, meaning that residents access insurance plans through the federal website, toll-free phone lines, or through local entities that have signed on to assist with enrollment.

Recognizing that many of those eligible for the subsidies and expanded Medicaid would be unaware of their eligibility, the federal government and states faced two challenges:

(1) how to conduct outreach about the ACA to low-income and hard-to-reach communities and those with language or cultural barriers, and

(2) how to enroll those eligible in the most efficient manner.

At the same time, federal and state officials realized that existing networks of state government and nonprofit agencies could help locate those eligible and streamline their enrollment for health insurance, because many uninsured households that are potentially eligible for the ACA already participate in human service programs such as SNAP, TANF and LIHEAP. Ideally, officials reasoned, households could apply for the ACA, and their eligibility could be determined through electronic data obtained and

ACA Resources for Agencies

- Agencies may have limited funding for ACA referrals; however, at a minimum, they can help applicants find navigators and Certified Assistance Counselor within their zip code area by accessing:
 - HealthCare.gov's [Local Help](#)
 - Get Covered America's [Find Local Help](#)
- For those agencies interested in partnering and becoming assisters such as navigators or CACs, they can find more information at the [Health Insurance Marketplace](#). This website provides information on the role of navigators and CACs and how to apply.
- For groups interested in successful strategies for outreach and enrollment, resources and tool kits are available from [Community Catalyst](#) and [Enroll America](#).
- Information on how the ACA has helped insure individuals in each state is available at [HHS.Gov/HealthCare](#). This website also tells whether states have expanded Medicaid and how many individuals attained insurance during the first year of the ACA.

shared by human service programs, rather than having applicants apply in person with paper documents. Likewise, the process could be reversed—information from ACA and other health programs, including Medicaid, could be shared with human service programs, e.g., SNAP, TANF, LIHEAP, etc., in order to verify eligibility and increase enrollment in these programs.

Implementation rules for the ACA require this kind of information cross-sharing under the broader concept of “interoperability,” which is defined as “the ability of two or more systems or components to exchange information and to use the information to make better decisions.” (For more information see: [Your Essential Interoperability Toolkit: An HHS/ACF Resource Guide](#), released in July 2012.)

Through interoperability, ACA planners envision clients having easier and more efficient access to health and human services through web portals, along with program administrators increasingly relying upon streamlined electronic data matches to verify eligibility criteria, enroll clients and perform case management functions. Paper documents would be required of the applicant only when information is not available electronically.

The goals of streamlined approaches are increased efficiency and accuracy, as well as lower administrative costs in obtaining eligibility data; increased efficiency of eligibility determination and verification; and fewer burdens on applicants.

This report will focus on the potential to streamline ACA eligibility determination, enrollment, and retention through coordination of human service and health programs, primarily through upgrades to information technology (IT).

This report also focuses on the potential of the LIHEAP network to enhance ACA enrollment efforts, including use of community action agencies that administer LIHEAP locally in about half of the states.

IT Upgrades

According to the Urban Institute, which has prepared several papers on integration of ACA and human service programs, many such programs have outdated IT systems. This hinders their ability to obtain up-to-date eligibility information through data exchange

es with other programs. The same is true of many states’ Medicaid IT systems. The Institute outlined the potential such upgrades have for LIHEAP and other human service programs in a [webinar](#) for LIHEAP grantees, presented by the Office of Community Services, Division of Energy Assistance in August of 2013.

States’ efforts to move toward what the Urban Institute termed “21st century data-driven eligibility determination” have been assisted by the availability of federal funds to upgrade and modernize their IT systems for health insurance under the ACA, Medicaid and human service programs.

States had until December 31, 2014, to obtain federal grant funding for IT activities related to building a state-based marketplace. Additionally, the federal government is paying 90 percent of Medicaid programs’ IT development costs to upgrade and modernize eligibility and enrollment systems. Under a waiver of normal cost allocation rules, human service programs, with some exceptions, are not required to share the costs of IT development that benefits Medicaid and the particular human service program.

Initially, these modernization funds were only available through the end of calendar year 2015. However, those funds are now permanently available, and the waiver of cost share rules has been extended through December of 2018. States are eligible for the modernization funds regardless of whether they chose to expand Medicaid under the ACA.

Once fully integrated, the systems should be able to handle eligibility for Medicaid as well as SNAP and TANF. Possible benefits of such integration, according to the Urban Institute, could include interfaces between Medicaid and the federal health care exchange, as well as human service programs allowing automated verification of Medicaid eligibility and automatic, or “fast track,” enrollment of recipients of human service programs into Medicaid and/or the ACA.

The potential exists for human service programs to use Medicaid, ACA and other health programs’ data to expedite verification and eligi-

bility determination for human service programs' applicants.

The challenges to such integration are many, not the least of which are the many state departments that would be involved and the number of existing eligibility and enrollment systems that must be phased out and integrated with the Medicaid system. Other challenges include gaining access to program records due to privacy and confidentiality rules, in addition to overcoming differences in eligibility rules among the various health and human service programs. For example, programs differ in how they define households and have different methods for counting income and assets. More information on how states can handle these challenges is available in the August 2013 [webinar](#).

In conclusion, the Institute says:

"Human services programs could gain significant rewards from integrating and coordinating their eligibility systems with those operated by health programs. ...In the medium term, health programs are likely to serve more low-income households than any other need-based program, particularly in states that expand Medicaid. They will thus garner information about the vast majority of applicants for and recipients of human services benefits, creating opportunities to leverage that information for human services programs to streamline enrollment procedures, save administrative costs, strengthen program integrity, and improve benefits access by trimming clients' paperwork burdens."

Integration Examples

Apart from the ACA, many states have been updating their client eligibility systems; moving toward more electronic data collection and storage; transferring to more web-based services; and relying less on paper documentation furnished by clients. This was done in part because of program integrity concerns. These efforts by LIHEAP programs are outlined [here](#).

It is also common in LIHEAP to rely on data sharing with larger programs such as SNAP and TANF in order to increase efficiency and expand program enrollment. For example, some states cross-check LIHEAP client information with their welfare department's database of other program recipients (SNAP, TANF, Medicaid, etc.), because many LIHEAP applicants are also recipients of one or

more of these programs. This cross-checking is more likely in states where LIHEAP is housed in the same department as the larger programs, but it also occurs in states where LIHEAP and these programs are in different departments. (See more examples [here](#).)

Beyond LIHEAP, it's clear that most states are moving toward upgrading and integrating their Medicaid eligibility systems. According to an October 2014 [article](#) from the Commonwealth Fund, all states have taken advantage of the opportunity to upgrade their Medicaid systems with the 90 percent federal funding match. A 2013 study by the Kaiser Foundation found that 45 states share Medicaid eligibility systems with SNAP and TANF.

It's less clear regarding the extent to which LIHEAP is or will be integrated with Medicaid, the ACA and other health care systems. A recent survey of state LIHEAP directors revealed that few had any knowledge of ACA coordination within their state.

The District of Columbia provides one example of the type of integration envisioned by ACA planners. It created its own health insurance marketplace, expanded its Medicaid program, and obtained federal modernization funds to revamp its IT system.

The District's Human Services Department, which administers a wide range of programs including Medicaid, SNAP, and TANF (but not LIHEAP), is working with the District's health care exchange, called DC Health Link, to develop a new eligibility system. That system will eventually link the marketplace with Medicaid and other human service programs across multiple departments, including LIHEAP, which is housed within the DC Department of the Environment.

The old eligibility system used for Medicaid, SNAP, and TANF is being phased out and replaced by a new system called District of Columbia Assess or DCAS. The goal of the system is interoperability, meaning that the various systems operated by different programs can communicate and data can be shared across multiple programs. The project is multi-phased with LIHEAP expected to be added to the system by the end of 2015. More details are available in the [DCAS Request for Proposals](#).

The DCAS system includes an online portal allowing residents to access health care and other human service benefits. It also features a digital imaging system for scanning and storing documents. Furthermore, system operators will be able to access the federal data services hub, created through the ACA, which allows states with proper systems to verify citizenship, immigration status, and tax information with the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service.

The states of Virginia and Missouri report that eligibility and enrollment systems modernization is taking place in phases and there are plans to integrate LIHEAP in the future. Neither of these states expanded Medicaid or implemented their own state-run health insurance marketplace.

In Missouri, an integrated eligibility system called the Missouri Eligibility Determination Enrollment System (MEDES) is being phased in and will replace an antiquated system that is used by Medicaid and other programs. Gradually, SNAP, TANF, Child Care and LIHEAP will be phased in. (All these programs are administered by the state Department of Social Services, and all currently share some client data through an existing system). The Medicaid portion of the new system was up and running during initial ACA enrollment last year. Through its interface with the federal health care exchange, a large number of potential Medicaid applicants were referred to the state for processing. This created a [backlog](#) the state was still working on late this year.

In 2010, Virginia embarked upon an ambitious modernization project called eHHR (Electronic Health & Human Resources) whose vision is “to leverage information technology to improve health care and human services for Virginians by providing access to the right services, to the right people, at the right time and for the right cost.” Utilizing Medicaid modernization funds, the project spans 12 agencies and numerous health and human service programs. The system is now functioning for health programs, and, in 2016, the state will migrate SNAP, TANF and LIHEAP to the modernized eligibility system. More information is available on the project [website](#).

Outreach and Coordination

In the above-mentioned [webinar](#) for LIHEAP grantees in August 2013, states were encouraged to use the nationwide infrastructure and delivery mechanisms of community action agencies (CAAs) to assist in ACA enrollment efforts.

Under the LIHEAP statute, states must ensure that the LIHEAP program is coordinated with other programs available to low-income households such as TANF, SSI, WAP, etc. In the model plan all LIHEAP grantees must submit, states must check off whether they use joint applications with multiple programs, referrals to or from other programs, one stop intake centers, or other methods.

A check of 2015 LIHEAP plans and a survey of state LIHEAP offices revealed little coordination with the ACA through outreach or referrals. Among the few examples:

- New Jersey CAAs participated in a program with the Corporation for National and Community Service (CNCS) that involved RSVP (Retired Senior Volunteer Program, a part of CNCS's Senior Corps). The state's RSVP programs were given extra funding from CNCS to assist with the ACA rollout and enrollment utilizing their RSVPs. The CAAs were provided with a VISTA (another program of CNCS) member to oversee the project locally.
- NORWESCAP, one of the participating CAAs, collaborated with LIHEAP so that every LIHEAP mailing included pertinent information for consumers interested in the ACA. While that project has been discontinued due to lack of funding, NORWESCAP is a Certified Assistance Counselor (CAC) agency and continues to use RSVP members as counselors to help clients interested in applying for the ACA. CACs and health care navigators are two of several new entities created under the ACA to advise and help consumers make health insurance purchase decisions. (For more information, see the ACA Resources for Agencies box on page 1.) Staff also helps at ACA enrollment events held by other entities.

- Another CAA in New Jersey, North Hudson Community Action Corporation, provides primary health care through health centers (in existence before the ACA) in a three-county area. Additionally, it has CACs at these health centers that provide information and assistance with the enrollment process for the ACA.
- Massachusetts continues a policy it has had for several years of tracking LIHEAP households' health insurance status during the intake and recertification process so that CAAs can provide referrals to health care, WIC and other nutritional programs. Additionally, the LIHEAP software has the ability to look up potential client eligibility through a statewide online system called the Benefit Enrollment and Coordination System (BECS). This system has the potential for linking with state health care sites.
- Minnesota asks on its LIHEAP application whether the applicant has health insurance and local service providers make referrals if needed.
- The North Dakota LIHEAP program has included a statement about the ACA on its Energy Share calendars.
- Missouri's Family Support Division of the Department of Social Services (DSS), which administers TANF, SNAP, Medicaid and LIHEAP, is establishing resource centers where clients can come in person to receive services. Resource center staff will assist in their communities by work-

ing closely with community partners to provide wrap-around services for the families DSS serves.

The lack of outreach activities connected with LIHEAP doesn't mean outreach isn't being conducted regarding the ACA. In the District of Columbia, for example, outreach and enrollment is conducted by [DC Health Link](#). Among its wide range of activities to enhance first year enrollment, it created enrollment teams that went to libraries, churches, laundromats and community events to offer residents and small businesses the opportunity to get information about health insurance plans, to find out if they qualified for subsidies to reduce premiums and to get assistance with the enrollment process.

It also developed a mobile phone app that provided users streamlined access to several key services on DC Health Link, including a premium cost calculator, an events calendar, and a GPS mapping feature that allowed users to locate a DC Health Link assistant or health insurance broker near them. Users could also access frequently asked questions, watch YouTube videos, contact trained experts, and share information about the DC Health Link mobile app through social media.

Elsewhere, various entities are conducting health care and human service enrollments through churches. In mid-December, Philadelphia's faith community held enrollment events, and some events went beyond health care enrollment to provide financial counseling and planning, health screenings, mental health screenings, appointments for city services, and information about LIHEAP.

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