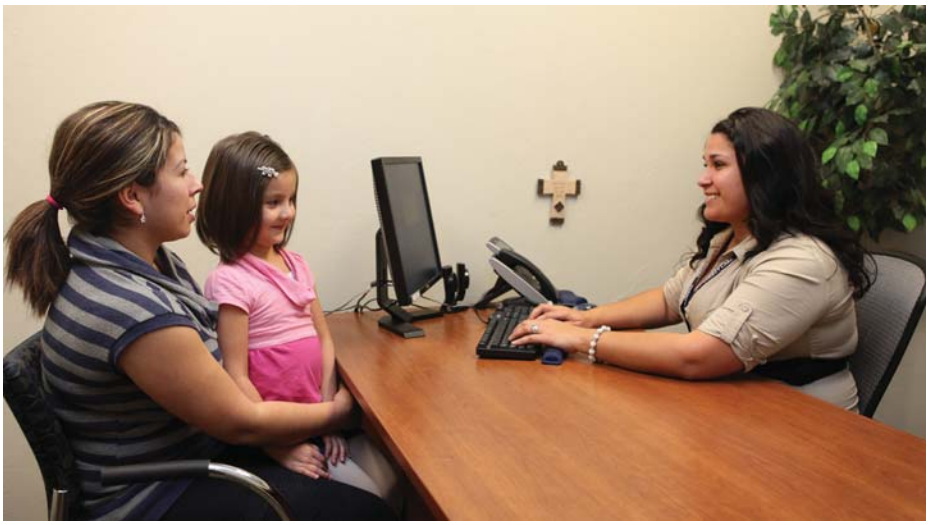

Outreach and enrollment: Karina Avila and her daughter Galali Arroyo sign up for Medicaid with the help of Raquel Palomino, a staff member at Variety Care community health center in Oklahoma City, Oklahoma. The state's "No Wrong Door" enrollment system led the way for other states in easing entry to Medicaid.

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Hard Work Streamlining Enrollment Systems Pays Dividends To The Sooner State

As states build sophisticated Medicaid eligibility and enrollment systems in the run-up to expanded coverage in 2014, they can look to Oklahoma for inspiration—at least in some respects.

BY ALICE M. WEISS

In the range of state positions on the Affordable Care Act, Oklahoma is firmly in the opposing camp. Oklahoma's Republican governor, Mary Fallin, sent back federal health insurance exchange implementation funds that the state had received as an "early innovator" in 2011. In November 2012 she rejected the option of expanding Medicaid or hosting a state-based exchange. Meanwhile, Oklahoma's attorney general, Scott Pruitt, has sued the federal government, arguing that in states like Oklahoma that have declined to set up exchanges, the language of the Affordable Care Act forbids the use of federal subsidies to enable their citizens to buy coverage through a federal or federally backed exchange.

Although these actions may not be surprising, given Oklahoma's conservative credentials, the state's resistance to implementation of the Affordable Care Act has been more unexpected in health policy circles. That's because the state has actually been a national leader in streamlining and modernizing enrollment in Medicaid and is the only state that has implemented real-time online enrollment—a key requirement under the health reform law that constitutes a major hurdle for most other states.

So it may be surprising that when it comes to enrolling its citizens in Medicaid, Oklahoma is a shining example of how to do things right. Over the past five years it has put in place the nation's first—and, so far, only—online application system for Medicaid. The state's automated eligibility determination system for Medicaid is among the most modern and efficient nationwide. According to an independent evaluation,[1] the state is expected to save almost $40 million over five years in staff labor costs alone as a result of these efficiencies and, in the process, achieve an almost three-to-one return on its investment in the fifth year of implementation in 2015.

In short, when Cindy Mann, director of the federal Center for Medicaid and CHIP Services, says the joint federal and state coverage program "is not your mother's Medicaid anymore," she may as well be talking about Oklahoma.

How the state got to this point constitutes a timely and instructive tale about the nitty-gritty of health reform implementation. It also shines a light on how a few forward-thinking individuals—most notably, Mike Fogarty, CEO of the Oklahoma Health Care Authority, which administers Medicaid in the state; and his division leaders responsible for implementation, Derek Lieser and Richard Evans (now no longer working for the state)—are role models for other states as they revamp their own enrollment and eligibility systems in the run-up to expanded coverage in 2014.

Oklahoma's Pathway

Oklahoma's dramatic transformation of Medicaid eligibility and enrollment

Photograph by Sheradee Hurst

began in 2007. After several incremental expansions of Medicaid eligibility beginning in late 1997, the state was poised to implement another expansion of Medicaid eligibility to low-income adults under a newly approved Section 1115 Medicaid waiver expansion authorized by the Centers for Medicare and Medicaid Services and the Oklahoma legislature. Over the previous decade the state had seen Medicaid enrollment more than double, from 281,000 in 1997 to nearly 607,000 in 2007. Still, in 2007 the state was eighth on the list of states with the highest uninsurance rates, with roughly 600,000 of its 3.3 million residents lacking health coverage. Four out of five uninsured people were adults; an equivalent proportion worked full time or lived in a household where someone did. Under the Medicaid waiver, the state hoped to expand its Medicaid program to certain adults whose income was below 200 percent of the federal poverty level.

Oklahoma's proposed coverage expansion under the approved Medicaid waiver was expected to enroll an additional 100,000 people. Fogarty, the Health Care Authority CEO, was in a characteristic bind: On the one hand, he worried that Oklahomans still associated Medicaid with welfare assistance, and therefore they might not sign up for enrollment in the expanded program. Fogarty's Health Care Authority Board had earlier identified Medicaid's link to welfare as a "structural weakness" and coined a slogan in 2003—"It's health care, not welfare"—to guide the agency's approach to expanding access to Medicaid health coverage while delinking the program from its historic welfare connections.

On the other hand, Fogarty also worried that the Health Care Authority had insufficient staff resources to handle a big increase in the caseload volume. So the state applied for and received federal Medicaid Transformation Grant funds that had been made available under the Deficit Reduction Act of 2005. The first goal was to develop and implement "No Wrong Door," an online application and automated eligibility determination system designed to streamline the enrollment process and manage the increased volume of cases. A new staffing model was created to support the overhauled enterprise, which essentially took the enrollment decision out of the hands of eligibility workers and relied on computers instead.

The implementation of No Wrong Door began in early 2008 and was completed with an online application launch in September 2010, a time frame of about two and a half years. In developing this new system, Oklahoma pioneered eligibility and enrollment policy innovations that are still reverberating within state and federal health policy circles.

Perhaps most significant, in automating the enrollment decision process, the state developed a so-called rules engine—a software system that executes one or more rules based on an algorithm typically phrased in an "if/then" form (for example, if this person's income is X, then he or she is eligible for enrollment). This system would accept someone's self-reported income upon application and then automatically verify income eligibility when the most recent relevant data for that person became available—for example, if a person applied in January, the system would apply the quarterly wage information for the applicant's January income when it is available the following April. Only if this additional documentation wasn't consistent with the person's original self-reported income would the system seek still more data.

The idea of using a rules engine and linking to electronic data sources was standard practice in a handful of states in 2007. But this "post-eligibility review" concept—checking self-reported income against other data that came later—was a radical concept when Oklahoma adopted it in 2010.

In Oklahoma as elsewhere, Medicaid eligibility had been structured according to rules dating from the creation of Medicaid as a welfare program in the 1960s. Under these rules, state agency workers' charge was "verify, then trust": Documentation of income, usually in its original paper form, was the only valid means of determining eligibility. In contrast, Oklahoma's new post-eligibility review made it possible to sign people up for Medicaid in real time and then revisit the decision later if the situation warranted.

In Oklahoma, about 82 percent of enrollees can now be enrolled automatically in Medicaid at the time when they apply. About half of these people must submit additional documentation for their eligibility to be determined.

Ripple Effects In The System

Oklahoma has experienced a rapid and powerful transition from paper-based and in-person transactions to a primarily electronic experience, and the effects of that transition for consumers and the state have cascaded throughout the system. Before launching the online application, Oklahoma allowed only paper or in-person enrollment—a real inconvenience for many working people and families. After two months of implementation, Oklahoma was receiving nearly 40 percent of its applications from people using the Internet to apply, submitting information from home. Today, 54 percent of Oklahoma's applications are submitted in this way, and only 6 percent are submitted on paper.

Online enrollment appears to have increased access for consumers. Because it is automated, Oklahoma's system can accept applications, generate documentation requests, make determinations, and enroll individuals into a plan twenty-four hours a day, seven days a week. As a result, more people can apply from home at their convenience, without taking time off from work. In calendar year 2011 one-quarter of online applications were submitted in the evenings or on weekends. And even when Oklahoma's state agencies were closed because of a blizzard in February 2011, the automated system kept working, enrolling 780 people.

With the transition to online enrollment, it became obvious that some people would lack access to a computer or Internet connectivity and that others would need help in completing an online application. The Health Care Authority trained partner agencies such as public health, tribal, and community-based organizations, including community health centers, to provide that help. It also set up a separate "agency view" version of the application for these assisters that enabled them to track applications and input additional data if necessary.

As a result, the assisting organizations could access data on Medicaid enrollment status, family composition, or

address from other programs; submit the completed application directly to the agency; and track its eventual disposition. Oklahoma estimates that about 80 percent of applicants who apply for coverage are "known" to the system—in other words, some of their personal information is already in Oklahoma's eligibility database and can be used to populate an application by the organization offering assistance, to avoid the need to start an entirely new application—and that some data are therefore already available to support the application. Allowing partner agencies and organizations to access this information speeds and integrates the application process for individuals and the state.

Reimagining The Staffing Model

In developing the online application and eligibility determination system, the Health Care Authority clearly hoped not only to make the processes more efficient, but also to reduce staffing needs. There had long been a statewide network of staff of Oklahoma's eligibility agency who were working in local offices and making eligibility determinations that would now be made together with the automated system. The authority created a new eligibility unit that was smaller and more centralized, to determine eligibility for Medicaid and other health programs in the state, as well as a centralized call center to manage inquiries and support applications. Local offices were allowed to accept in-person applications.

The Health Care Authority's staffing model presented some early challenges. Oklahoma had planned to add staff to help run the program but wasn't able to secure funding from the state budget. In the first three months of implementation, the overall response rates to new online applications dipped from about 75 percent to just over 50 percent, demonstrating that the centralized unit was struggling to keep up with new applications in the system.

The call center was also overwhelmed by the volume and complexity of calls that it received during its first six months of operation. The average call time ballooned from 13 seconds in the month prior to launch to a 3.5-minute average over the next six months. About a quarter of the people who called in the first few months got a busy signal, and about a third of those placed on hold ultimately hung up.[1]

By January 2011 the centralized unit's response rate to new online applications was above 90 percent; it stayed in that range through June of that year. The call center performance also increased, with average time to answer a call stabilizing at about a minute and the percentage of calls placed on hold, after which the caller hung up, dropping to 11 percent by June 2011. Now, four years after full implementation of the Medicaid waiver, Oklahoma expects to receive a substantial return on its state investment in the No Wrong Door strategy. According to an independent evaluation by the Pacific Health Policy Group,[1] over the first five years of the program, from 2008 to 2013, Oklahoma has invested $14.5 million in state funds to operate the new system and is expected to save roughly $36.7 million, mostly on staffing costs. Not counting the $5.1 million in federal dollars that Oklahoma received through the Medicaid transformation grant to develop the system, the five-year return on the state's investment will be $22.2 million, or 153 percent.

Lessons For Other States

As noted, Oklahoma has for now rejected the Affordable Care Act's Medicaid expansion and a state-based exchange. Although Oklahoma already covers some low-income adults through its 1115 waiver—adults who, in other states, would be eligible for the Medicaid expansion—there are estimates that 150,000 low-income Oklahoma residents may remain without health coverage as of 2014.

Nonetheless, even as Oklahoma declines to proceed with these aspects of the law, other states are in a position to benefit from the state's earlier moves as they redesign their eligibility and enrollment processes for Medicaid, the Children's Health Insurance Program, and the exchanges. The Affordable Care Act requires states to have a common portal for enrollment in Medicaid and CHIP as well as in the exchanges—a broader version of the No Wrong Door concept that pertained previously just to Medicaid. That means other states now have the opportunity to install an entirely new real-time electronic enrollment system funded generously with federal support. They can also use the need to have a common system of enrollment across programs to rethink and reinvent staff roles and responsibilities to promote efficiencies.

Other states can also learn from the vision and transparency of Oklahoma's leaders, who reimagined how the Medicaid program could work and were able to implement that vision. At the same time, they recorded and shared metrics to use in monitoring the state's performance. Having these data helped Oklahoma and its partners identify and solve problems along the way. Other states could do well to follow similar practices as they embark on their own transformations.

The official motto of Oklahoma is *Labor omnia vincit*, Latin for "labor conquers all things." In this case, the state's hard work in creating a state-of-the-art Medicaid enrollment system clearly vanquished inefficiencies and enrollment barriers that used to cost extra money for the state—and coverage for thousands of people who now have Medicaid instead. ■

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NOTE

1 Pacific Health Policy Group. State of Oklahoma health care authority "No Wrong Door" online enrollment: independent evaluation final report. Highland Park (IL): The Group; 2011.