Building Blocks for Universal Health Care in New York: Bridging Coverage Gaps with Information Technology

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KEYNOTE ADDRESS

Enrollment Modernization: Changing the Culture, Organization and Structure of Health Program Enrollment

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Good afternoon. It is a pleasure to be here.

While I have been asked to share the work that the California HealthCare Foundation and others have been doing over the past 10 years to modernize enrollment, I would be remiss if I didn't first mention how impressed we in California are with the progress New York has made in using health IT to improve the quality, safety, and delivery of care.

New York City's effort to create the nation's largest community-based health records network, the $105 million HEAL NY grants program, and the NYeC public-private partnership, are evidence of a bold vision. The leadership required to put these programs in place, the strategic approach to effectively use what surely are scarce resources, and the early success you are having in execution all attest to the strength of that vision.

In talking about modernizing enrollment, I'm going to focus on three topics:

- The major obstacles to implementation;
- The role technology can and cannot play; and
- The key lessons learned in California and how they might help inform efforts here in New York.

I use the term "modernization," which I acknowledge sounds much like the period in the United States between 1950 and 1965 that involved a series of changes in economic organization, political structures, systems of social values, and the introduction of so-called "modern" appliances. But I use the term intentionally, because we need to change the culture, the organization, and the structure of how program eligibility is determined and how enrollment activities are carried out.

Context
I want to start by setting a brief context for how California and New York compare with respect to program enrollment, eligibility policies, and the uninsured.

Both states have made progress in reducing the complexity of program enrollment, including the development of a joint application for Medicaid and SCHIP. There is, however, much work still to be done in both states to reach those who are eligible, but not enrolled, which is why it is essential to make the enrollment process less cumbersome. It would also help to reduce the high level of "churning" that is administratively expensive and disruptive to the continuity of care.

COMPARING CALIFORNIA AND NEW YORK
Program Enrollment, Eligibility Policies, and the Uninsured

	California	New York
Enrollment		
Medicaid enrollment each month	6.34M	4.13M
SCHIP enrollment each month	986,311	394,164
Eligibility Policies - Simplification / Streamlining		
No asset test for pregnant women and children	Yes	Yes
Presumptive eligibility for pregnant women and children	Yes	Yes
12-months continuous eligibility for children	Yes	Yes
Eliminate face-to-face interview requirement	Yes	No
Self-declaration of income	No	Yes*
Uninsured		
Percent of population that is uninsured	19%	14%
Number of uninsured	6,774,000	2,568,000
Percent of uninsured eligible for government insurance programs	18%	41%

*Re-certification only
Sources: Kaiser State Medicaid Facts; Commonwealth Fund; California Health Interview Survey.

Major Obstacles to Modernization

Let's start by identifying some of the major obstacles to modernizing enrollment. The current system of categorical programs, each with its own separate application form, eligibility rules, document requirements and enrollment processes, make applying for services a complex and confusing maze for most families.

In California, families need to navigate among Healthy Families, Healthy Kids, CalKIDS, Kaiser's Children's Health Plan, and Medi-Cal (California's version of Medicaid), which has 165 different aid codes. These categorical funding mechanisms contribute to service fragmentation, discontinuity, and redundancy, making the enrollment process terribly inefficient.

Applicants wishing to apply for multiple programs repeatedly must provide what is essentially the same information more than once, often at different enrollment locations. Families experience a world of siloed enrollment processes, supported by stand-alone enrollment systems, which serve as barriers to those seeking coverage and care. Families should not have to understand the maze of programs or the distinct eligibility rules that apply for each in order to get the care they need.

Requiring a family to show up in person to a welfare office and spend up to three hours enrolling in a single program – which happens in California and likely also in New York – simply does not make sense, especially since most of the applicants for these programs are working families.

Remember the 1996 Clinton Welfare Reform effort? One of its key components was delinking health coverage from welfare. Yet no one bothered to "de-link" the enrollment and eligibility processes, which are still largely in place across the United States, including the association and stigma with welfare that delinking was intended to eliminate. Medicaid and welfare enrollment remain joined at the hip in both perception and reality, which is likely because Medicaid funds are being used largely to finance the legacy welfare enrollment systems.

Another major obstacle to enrollment modernization exists: California and New York, like most other large states, lack a unified statewide approach to streamlining enrollment processes for the states' health and social services programs. This makes it impossible to ascertain the full range of services a family may be eligible to receive. It is also worth mentioning the still persistent culture, in some quarters, of eligibility workers believing it is their job to divert applicants from public assistance.

California and New York also use outdated and disparate technology systems—making it difficult to make policy changes quickly and accurately, or to appropriately exchange or share information among programs. Many of the activities that support enrollment processes in both states are still manually performed, which is expensive, time-consuming, and prone to error.

In addition, the lack of integrated systems precludes families from taking advantage of the benefit of existing flexibilities in federal law that permit agencies to use information provided by a family to maintain eligibility for one program, for example, Food Stamps, to also renew the family's Medicaid coverage automatically.

In California, an example of this problem was the effort to promote Express Lane Eligibility—to presumptively enroll children in Medicaid who were eligible for free meals at school. It was not as successful as it could have been because of an inability to process massive amounts of information electronically, even though eligible but not enrolled children had been identified.

Similarly, current efforts in California to directly certify and enroll children who participate in Medicaid for free or reduced-price school meals, without the need for additional paperwork, is challenged because of the inability to match Medicaid income data electronically with school meal eligibility limits, as that data is stored in individual county welfare systems, not in the statewide Medicaid database.

This brings up the last major obstacle. In many large states, including California and New York, eligibility is determined at the county level. In California, we have 58 county jurisdictions; in New York there are 57. So New York, like California, has many distinct enrollment jurisdictions. As we say in California, if you've seen one county, you've seen one county…

Developing a more streamlined approach in such a disaggregated environment is difficult when there are so many interested stakeholders, complex labor issues, legacy systems, and, I suspect, a few entrenched vendors.

The Role Technology Can and Cannot Play
All this brings us to the role technology can and cannot play in enrollment modernization. Let's start with what it cannot do. Technology on its own will not bring reform. It is not a magic transformational bullet, as some might have us believe.

Establishing new electronic systems that mimic the old *offline* processes is, frankly, a colossal waste of time. Similarly, I would argue that investing additional resources to develop new "screening only" applications is equally a waste of time and resources—as the tools, expertise, and experience with electronic enrollment have been proven to be effective.

I want to share ways in which the effective use of technology in California has been a catalyst to make enrollment more efficient and more consumer-friendly.

Health-e-App
In 1998, the State of California issued a 28-page joint application for "expedited enrollment" for children in Medicaid and SCHIP. The application had a four-page worksheet for families to complete, with income and expense tables, requiring the family to make multiple calculations. It also contained two envelopes – one blue, the other green.

A family was to determine which program their children were eligible for, then submit the application to either the state for SCHIP, using the blue envelope, or, if the family determined a child was eligible for Medicaid, they were to check one of 58 county boxes—on the backside of the green envelope, and mail it to a drop box, which then forwarded the envelop back to the county in which the application originated. When we looked at this application, we said if ever there was a candidate for automation, this was it.

In partnership with the California's Health and Human Services Agency, the California HealthCare Foundation financed the design, development, testing, and implementation of a commercial grade, Web-based application that automated the enrollment process from end-to-end.

Called Health-e-App, the application had the following features:

- An interactive Web-based interview process to collect and error-check application data, based on the design approach first pioneered by Intuit's Turbo Tax, which significantly improved the quality of the application data and decreased the number of incomplete applications.
- Preliminary eligibility determination online, available within seconds of application submission.
- Ability to pay premiums online—using a debit or credit card or electronic check.
- Ability to select a health and dental plan and/or a provider by searching a database of providers by language spoken, proximity to one's home, specialty offered, or hours of service.
- Ability to toggle between languages, in real time, and print forms in multiple languages.
- Use of an electronic signature.
- A customized checklist of the required documentation, including a bar-coded fax cover sheet that links the faxed documentation to the application data.
- Electronic confirmation that an application was received, including a confirmation number and a phone number to check the status of the application.

The Lewin Group, a national health care consulting firm, conducted an independent business case analysis of Health-e-App's use in community health centers, schools, and churches in San Diego County, where it was piloted. The findings included:

- A 40 percent reduction in application errors.
- A 21 percent reduction in eligibility determination time.
- High degree of satisfaction from program administrators, applicants, and Certified Application Assistors, who help families apply for coverage.
- Ninety percent of applicants reporting that they would rather apply online.

The California HealthCare Foundation provided the State of California with a no-cost, perpetual license to use Health-e-App. Today, 20 percent of California's applications for SCHIP and Medicaid

for children are delivered electronically. And the state provides a financial incentive to those who assist families with completing applications online.

Last year Governor Schwarzenegger proposed, and the legislature approved, making Health-e-App publicly accessible, so that families can apply from home, the library, or wherever Internet access is available.

One-e-App

In an earlier panel you heard Tangerine Brigham discuss San Francisco's use of One-e-App, as the enrollment system for San Francisco's universal health care program. One-e-App is the next generation of the Health-e-App platform. The California HealthCare Foundation and The California Endowment created [The Center to Promote HealthCare Access](#), a California-based nonprofit organization, to manage One-e-App's development and operation.

As its name indicates, One-e-App was designed to be a single application for a *range* of publicly financed health and social services programs.

- It recognizes which data elements are required by different programs;
- It collects that data once;
- It runs the data through a sophisticated rules engine to screen applications electronically against the eligibility requirements of the various programs;
- It provides a list of programs for which each family member appears to be eligible; and
- Based on the *choice* and *consent* of the applicant, One-e-App – wherever possible – electronically delivers completed applications to the appropriate agency or agencies for final eligibility determination.

One-e-App is currently in use in 10 California counties, including eight of the largest 15 counties in the state. It is used by health plans, community health centers, other community-based organizations, hospitals, Certified Application Assistants and others. It works in call centers and wirelessly for use in outreach efforts or remote areas. One-e-App has all of the features previously mentioned for Health-e-App and, in addition:

- Further simplifies reauthorization and renewal by electronically storing permanent and temporary verification documents, which reduces or eliminates the need to re-submit those documents.
- Provides robust case management tools to review, assign, and track applications.
- Recently has been upgraded to print a completed Earned Income Tax Credit application.

At some point I expect it will even help family members to register to vote electronically, a concept voting rights activists Francis Fox Piven and Richard Cloward first advocated some 35 years ago.

In addition to health program enrollment, a version of One-e-App being used in Arizona supports electronic enrollment in food stamps and TANF, which will soon be available in counties in California. While still far from a perfect solution, One-e-App has come close to realizing the proverbial "no wrong door" approach to enrollment that many of us have been touting for years.

However, and this may come as a surprise, the most significant lesson learned, which also serves as the segue to the last part of my talk, is that it is not realistic, practical, or even possible to modernize

enrollment by *only* automating the front-end of the application process. Though our experience with One-e-App, it has become clear that without also addressing the inefficiencies of the "back-end" systems, at some point you simply begin to automate the dysfunction that exists beneath.

Key Lesson Learned
Let me elaborate on that last point. In 2007, the California HealthCare Foundation and three other California foundations commissioned an independent assessment of California's health care program eligibility requirements and associated information technology systems.

The report, *Modernizing Enrollment in California's Health Programs: A Blueprint for the Future*, identified overarching problems with current enrollment processes and recommended the State of California adopt an "enterprise" approach to streamlining and integrating the enrollment process through both:

- A *Web-based, self-service application*, like One-e-App, that would allow consumers to apply online for a range of programs from any location, at any time of day, and

- A *"back-end" infrastructure* that would serve as the platform to build a repository of shared business rules and common "services."

This approach is called a Service-Oriented Architecture (SOA). Let me use a familiar analogy to describe what a service-oriented architecture is.
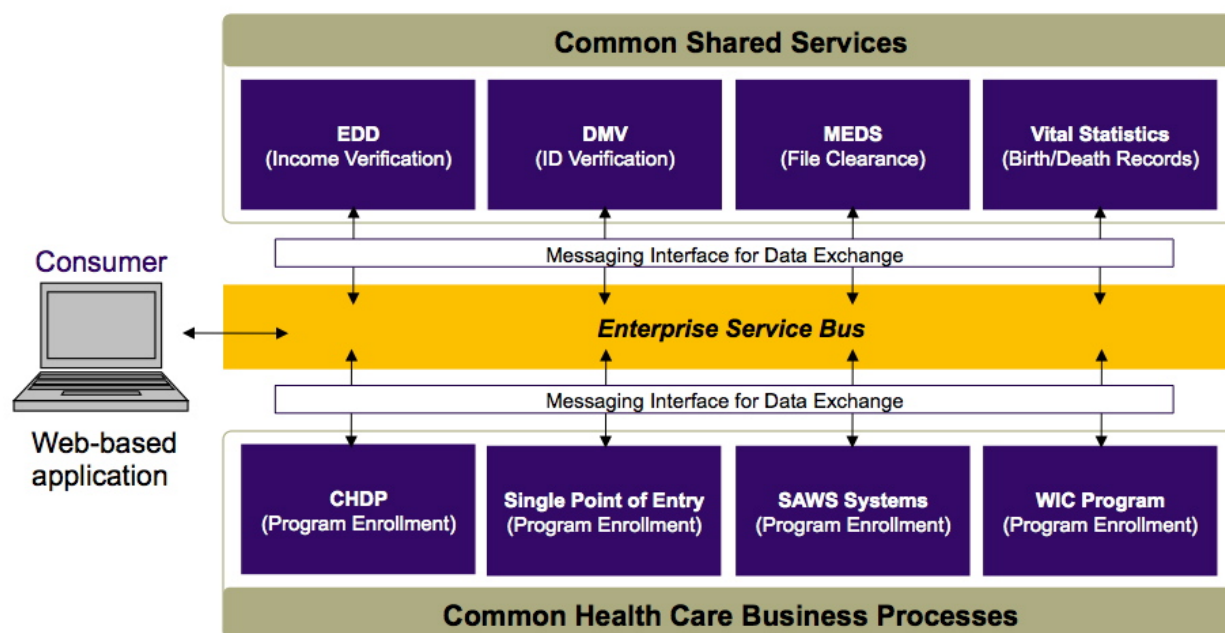
How many of you have ordered a book on Amazon.com and paid for it using a credit card or PayPal? Those are two distinct "services": ordering and payment. Do you remember seeing the list of books people bought who also bought the same book that you did? That's a service called personalization. Did you ever buy a book on Amazon as a present and have it gift-wrapped and shipped? These are two additional services: gift-wrapping and fulfillment.

If you've taken advantage of any of these services, you've benefitted from a service-oriented architecture.

SOA is a platform for creating and using business processes, packaged as services. The combination of ordering, payment, personalization, gift-wrapping, fulfillment, and more than 150 similar services help Amazon better serve its 60 million customers.

The services communicate with each other by passing data from one service to another—using what's called an Enterprise Service Bus, or the communications nerve center for sharing and using services. The services are built using industry-standard protocols. The communication can be simple data exchange or it can involve two or more services coordinating a specific activity or a business process, such as eligibility determination and enrollment.

SERVICE-ORIENTED ARCHITECTURE
A Prototype for Modernizing Health Care Enrolment

Common Shared Services

| EDD (Income Verification) | DMV (ID Verification) | MEDS (File Clearance) | Vital Statistics (Birth/Death Records) |

Messaging Interface for Data Exchange

Consumer

Enterprise Service Bus

Web-based application

Messaging Interface for Data Exchange

| CHDP (Program Enrollment) | Single Point of Entry (Program Enrollment) | SAWS Systems (Program Enrollment) | WIC Program (Program Enrollment) |

Common Health Care Business Processes

Source: *Modernizing Enrollment in California's Health Programs: A Blueprint for the Future*, 2007

In an SOA environment, applicants for public programs would be able to apply for services from 'any door;' and would share information only once, regardless of the number of programs for which they are applying. Information would be electronically shared via online, real-time connections. For example supporting documentation or birthplace would be confirmed online, through a "verification service."

The California Health & Human Services Agency, which oversees the state's health and social services programs, has recently endorsed this approach, and several California foundations are in discussions about assisting the state to design the architecture and study the costs and benefits of building it.

Key to its success would be the establishment of a statewide governance mechanism to provide a framework and a discipline for structuring and governing information systems. This framework could improve operational efficiency regardless of departmental and technological boundaries.

The governance mechanism would also serve as the forum for involvement from multiple stakeholders, including representatives from local jurisdictions, health plans, labor, consumer groups, and other stakeholder representatives.

Executive-level sponsorship is critical to support the development of an IT infrastructure that allows for the exchange of information *across* programs. Change is difficult, especially changing the culture and organization of 40 years of enrollment practices. Bureaucracies by their very nature can grind a project to a near standstill if a well-informed, committed, and active leadership is not present at all levels.

An effort like the one outlined here would also require standardizing data elements and harmonizing privacy and security policies across programs to enhance communication and make data-sharing possible, where appropriate.

The good news is that SOA can work with existing legacy systems. Federal dollars for this type of system enhancement are available at a favorable match rate of 75 to 90 percent, based on the specific activity, especially if the enhancements are consistent with the new federal Medicaid Information Technology Architecture (MITA), which is intended to foster integrated business and IT transformation across the Medicaid enterprise.

Again, deploying new technology alone will not be sufficient. And SOA is not necessarily proposed as a panacea or even as a single available solution. Efforts to further reform and simplify enrollment and eligibility policies and processes must also continue.

Conclusion

I would like to leave you with a few concluding thoughts. Small bureaucracies are obviously easier to refashion than large ones. The changes required to modernize enrollment will be complex and challenging, and would undoubtedly be disruptive to established public sector structures, culture, and management arrangements. Public sector investment in technology is constantly challenged by the cultural change required to realize its potential.

Yet, as we've heard here today, other states and other jurisdictions have started to realize the potential that new technology offers in this area. The risk for policymakers and other decision makers may be great, but the benefits can longer be ignored.

Public services need to be as easy to access and use as anything else technology has helped facilitate in our society. The public deserves it and together we can make it happen.

I leave you with the development philosophy that has guided the California HealthCare Foundation's work in this area for the past 10 years. We refer to it as radical incrementalism. It's a development approach usually typified by rapid "waves" of near-term (6 to 12 month) initiatives, organized around a clearly articulated longer-term (5 to 10 year) strategic direction. The basic concept is that the best way to drive major change is through a series of smaller, successful waves. While each success represents a small step in the right direction, if successful, the overall cumulative effect can create radical change.

Through a series of well-designed and well-executed steps, the goal of making enrollment a more efficient and more consumer-friendly process can certainly be achieved.

Thank you.