

**HIT Policy and Standards Committees
State Perspectives on Implementation of Initial 1561 Standards**

November 10, 2010

Background

Please provide high-level information to the workgroup for understanding how your state agencies and programs are structured.

1. Who administers your Medicaid, CHIP, SNAP and/or TANF programs?

a. Are these programs administered at the State or County level?

Answer: The State of California, Department of Health Care Services (DHCS) is the single-state agency for the State's Medicaid program, called Medi-Cal. The State of California, Department of Social Services (DSS) is responsible for the State's TANF program known as CalWORKs and the State's SNAP program, known as Cal Fresh. The Managed Risk Medical Insurance Board (MRMIB) administers the State's CHIP program, called Healthy Families Program and all administration is performed at the state level. California has taken advantage of the ability under Section 1931(b) of the federal Social Security Act to expand Medi-Cal to ensure that all recipients of CalWORKs are eligible for Medi-Cal under Section 1931(b) to avoid the need for two eligibility determinations.

b. Does the same agency administer each of these programs? If not, how is administration divided among state and/or county agencies?

Answer: The two departments and the one board are organized under the umbrella of the California Health and Human Services Agency. The DHCS maintains the Medicaid State Plan and implements Medi-Cal policy through state laws, regulations and guidance to counties and providers. The counties have formed three consortia to implement the Statewide Automated Welfare System (SAWS) and each utilizes its own computer system to determine eligibility for Medi-Cal and other public programs and to send eligibility information nightly to the State's Medi-Cal Eligibility Data System (MEDS), a state operated and maintained legacy system which serves as a central repository from which information is accessed by providers to verify program eligibility, income spend down and the existence of other health coverage. Two consortia are operated by multi-county joint powers agreements and supported by separate systems from Hewlett Packard and Accenture; Los Angeles County has its own system, supported by a system from Unisys. CHIP has its own separate system, supported by a system from MAXIMUS.

c. Does the same agency that administers the program perform eligibility determinations? If not, how is this responsibility divided?

Answer: Medi-Cal eligibility determinations are split between the state and county. DHCS establishes all policies for Medi-Cal eligibility and these policies are operationalized by County Welfare Departments (CWD) for the majority of the Medi-Cal program. Medi-Cal case records are maintained within each county, of which there are 58 in California. DHCS does have a small number of state staff that determines eligibility for Medi-Cal's Breast and Cervical Cancer Treatment Program (BCCTP).

d. What role, if any, do community-based organizations play in the eligibility determination and enrollment processes?

Answer: California uses a joint application for the Healthy Families Program and Medi-Cal for children and pregnant women. This application can be submitted on line to a vendor who screens these individuals for program eligibility. Application assistants within community-based organizations are also used for submitting applications for children and pregnant women to establish presumptive eligibility until the

final determination is made by the CWD. DHCS also utilizes the screening eligibility determinations made by qualified entities to establish presumptive eligibility in an automated fashion for the BCCTP. Some counties also outstation Medi-Cal eligibility workers at their county hospitals to conduct onsite eligibility determinations for hospitalized individuals. Community-based organizations are also used to enroll participants in various waivers and to provide information to assist aged, blind and disabled individuals to continue eligibility for Medicare and Medi-Cal. Community-based organizations also assist clients to complete online applications that have been developed and implemented by two of the three SAWS consortia projects.

2. *Please discuss the level of system integration your state currently has for the Medicaid, CHIP, SNAP and TANF programs.*

a. Is there a state repository of information that provides information on a consumers' enrollment in programs (e.g., master client index)?

Answer: Yes. MEDS is the single repository of eligibility information of all individuals known to Medi-Cal, the Healthy Families Program and welfare programs in California. Information from MEDS is used by providers to confirm Medi-Cal eligibility. However the SAWS systems and the system operated by the vendor for the Healthy Families Program are stand-alone systems and do not communicate to one another – their only common denominator is the input of data into MEDS.

b. Can consumers apply statewide to any single or multiple programs online? If so, does the online process include submission of documentation? E-signatures? If all application data and documentation is submitted, is the applicant required to come in to an office? If yes, for what purpose and for which specific programs?

Answer: The only statewide online enrollment system in California is one we are standing up this month for CHIP and Medicaid for Children. It automates enrollment end-to-end, including support for electronic documents, e-signatures, real time payment of premiums using checks, debt or credit cards, and real time preliminary eligibility determination in a matter of seconds. The app also supports multiple languages with a real time toggle between Spanish and English. Applicants do not need to come in to an office to apply or to be enrolled.

Two of the county consortia received USDA grants to automate enrollment in the SNAP program. They are each developing separate web-based systems for Medicaid, SNAP and TANF that at this point do not fully automate the enrollment processes. Eligibility workers perform manual data entry, after receipt of the online application in one system; office visits are still the norm; and neither system supports e-documentation, as of yet.

3. *Please tell of us of any recent innovations in enrollment in your state and/or of any early preparations you have made for enrollment under the Affordable Care Act.*

Answer: California preparations for enrollment under ACA include the enactment of State law to establish the governing board of California's Exchange, to implement the Exchange and to provide coverage to individuals previously ineligible for Medicaid under the federal Social Security Act with incomes up to 200 percent of the federal poverty level. This newly covered population will be enrolled in county-based coverage programs, consistent with the terms and conditions of our recently approved federal section 1115 Bridge to Health Care Reform Demonstration Waiver. The covered populations under the waiver are individuals who will be the "newly eligible" under Medi-Cal come 2014.

Core Data Elements

b. Does your state currently use the National Information Exchange Model (NIEM) guidelines to exchange data elements between health care programs?

Answer: California DHCS does not exclusively use the NIEM guidelines for all data exchanges. This is primarily due to being on a legacy platform that is 40+ years old.

a. If no, do you use NIEM to exchange data elements in any other domains? What alternatives do you use to ensure consistent, efficient and transparent exchange of information between programs?

Answer: DHCS uses standardized file formats for data exchanges where feasible and partners can collaborate, such as NCPDP file format for pharmacy provider files and 35C format for paid claim data. California DHCS plans to use NIEM guidelines for data and file format for any new system development efforts including the Health Insurance Exchange.

We recently conducted a six-month study across 12 different programs, including 6 different state enrollment systems, and found significant variation in the format, description and definition of core and other data elements.

NIEM would offer a way for California to harmonize its data exchanges without ripping and replacing current systems. We would support its use.

2. What is the biggest current barrier(s) to exchanging eligibility and enrollment data between health and human services programs (e.g., Medicaid, CHIP, SNAP and TANF)?

Answer: Data exchange primarily is asynchronous due to batch driven processes currently. To go to real-time data exchange and processing in some senses would be a major effort due to architectural limitations and the requirements of down-stream required batch processing as the MEDS eligibility system is currently designed. Additionally California does not have a single integrated eligibility system that can share information across programs; there are multiple applications for program eligibility which all collect similar information, and having a 44 year old mainframe legacy system as our central data repository. Any move towards such system development and implementation will require a significant amount of financial and staff resources to accomplish; this would be a project that will take several years to plan, develop, implement and evaluate.

Verification Interfaces

1. Does your system currently use a real time (Web services) approach to obtain verifications from Federal and/or State data sources?

Answer: The MEDS application is a COBOL and CICS based Legacy mainframe application and is not based on Service Oriented Architecture concepts/framework. The SAWS systems have not implemented real time web services from Federal or State sources; however, 2 of the 3 are based on Service Oriented Architecture concepts/framework.

California's CHIP program participates in the pilot Social Security Administration effort to verify birth certificates. This is an overnight batch process, which we understand will conform to the ACA's real time requirement. We are quite pleased with how this system works today.

a. If not, what would it take to do so?

Answer: A major modernization effort of the MEDS system. With the current MEDS legacy system, the most effective way appears to be exposing Application Program Interfaces (API's) and having web services call those API's for reads, updates, and insert functions. Enhancing the SAWS systems to use real-time web services for verifications would be a significant modernization but smaller in scope than updating MEDS as two of the three are already web-based applications.

d. Have you ever encountered a situation where a Web service would not be the preferred approach?

Answer: DHCS sees significant value in the leveraging of web services, though current system architecture is a barrier to this technology.

2. ACA Section 1561 Standard 2.2 states that future iterations of the Federal reference software model should include additional interfaces to Federal, State or other widely-available data sources including the National Directory of New Hires, the Electronic Verification of Vital Events Record (EVVE) system, State Income and Eligibility Verification (IEVS) systems, Public Assistance Reporting Information System (PARIS) and the U.S. Postal Service Address Standardization API.

a. Real-time, web services access to which of these interfaces is most critical for your state and why?

Answer: To the extent possible, having real-time access to all of these interfaces would be desirable in terms of processing applications and having readily available information to make accurate eligibility determinations as soon as one can since these interfaces provide different information and/or validation of submitted information. This helps to lessen impacts on applicants and beneficiaries in terms of information they need to provide for establishing initial and ongoing program eligibility and lessens subjectivity when making such determinations. Also by having this information readily available helps to more accurately determine eligibility for public programs, helps to lessen duplication of effort, could be used to ascertain eligibility for more than one public program, based on the needs of the individual, and can be used to determine when eligibility for program services no longer exists (such as is the case with death records).

b. Are there any additional interfaces that are critical for your state?

Answer: NCPCP for pharmacy data exchanges

Business Rules

1. How does your state currently incorporate business rules in your transaction systems?

For eligibility determination and benefit calculation, the business rules reside in the SAWS systems, each of which uses different software tools to incorporate the rules. For MEDS, California DHCS business rules are incorporated into the source code COBOL language of the mainframe application.

a. What standard do you use for consistently expressing rules? Internal best practices as derived and acquired over supporting the eligibility system for several decades and project best practices including IEEE standards.

b. If so, what benefits have you seen from doing so? What challenges did you encounter? No real benefits as we are not using a business rules engine and Business Process Execution Language (BPEL) to orchestrate services and streamline engineering of business rules.

- c. *If not, what (if any) challenges has this presented? What strategies do your systems currently employ to ensure the capacity and flexibility to change and/or modify rules as needed?* MEDS is not a flexible system. Having a Business Process Execution Language (BPEL) engine to enable orchestration of services would be wonderful, but the department is not there with current architecture.
2. *How could eligibility determinations made from these business rules be presented to consumers in a more clear, concise and unambiguous manner?* By standardizing Notice of Actions and by applying established health literacy principles to consumer communications, including but not limited to, reliable readability tests at an appropriate grade-level, using focus group testing, ensuring accurate and concise translations and ensuring communications for the blind and disabled are readily available. For example, by using clear, unambiguous language, such as your child or family was denied coverage because your family's income exceeded the maximum allowable income, which is \$xx/month for a family of xx. Your family's income was \$xxx
 3. *Is additional standardization of business rules necessary to make the business rules repository proposed in Recommendation 3.2 a valuable resource? Yes*
 - a. *What strategies would you suggest for contributing to and/or maintaining such a resource?*
Recommend first assessing the as-is, and working with industry experts to target a to-be model.

Transmission of Enrollment and Eligibility Information -

1. *Does your system currently use existing HIPAA standards to transmit eligibility and enrollment information to other entities?*

Answer: Yes, we do and so do our partner public and private health plans.

Privacy and Security

1. *How, if at all, does the consumer interact with your system(s)?*

Answer: They do not interact with the MEDS system. However, the three SAWS consortia and the Healthy Families Program have developed online application processing for individuals to apply for program services vs. having to go through application assistants or coming into a CWD at the local level. The online applications may be made for Medi-Cal, CalWORKS, or Cal Fresh and have been implemented in two of the three SAWS systems. The Healthy Families Program is establishing a web-based portal for online applications by individuals and this functionality should be fully operational by early 2011. With our new statewide CHIP and Medicaid for Children system, applicants can enter their own information, suspend and save their information at any point, return to the system to complete their application.

- a. *How difficult would it be to modify your system to offer consumer access to and control over eligibility and enrollment information?*

Answer: This would be a major work-effort requiring the redesign of the MEDS system. This includes, rearchitecting, rewriting MEDS in new open architecture standard to be able to leverage services, as

well as designing and developing work-flow and revamping consumer access via security. In terms of the SAWS systems, this too would be a significant work effort as the online application systems currently do not determine the consumer's eligibility in real time and do not do so without the assistance of county eligibility workers.

b. Where is the greatest opportunity to do so?

Answer: Although the SAWS consortia systems continue to add functionality to improve consumer access and control over their eligibility information, significant improvement of the online consumer experience will require development of real-time web services for verification of client data. Perhaps the online enrollment component and portal components of the solution. The greatest and most immediate opportunity would be to build this desired functionality into a new state-level Exchange enrollment system. There are state-level statutory and practical issues, which would need to be addressed and resolved.

c. What is the greatest challenge?

Answer: Resources, competing priorities, and tight mandates via the Federal Government related to ACA implementation timelines.

d. Legal or statutory barriers?

Answer: None identified.

2. The initial 1561 standards recommend that all entities involved in health information exchange follow the full complement of fair information practices (FIPs) when handling personally identifiable health information. How does your state incorporate the fair information practices into your eligibility and enrollment systems for Medicaid, CHIP, SNAP and TANF?

Answer: The SAWS systems follow all applicable federal and state mandated security standards. In MEDS, for inquiry purposes, counties and external entities have real-time secure access to eligibility data. PHI and PII data are protected departmentally via documented policies and any new access to eligibility data for county or provider workers must follow the MEDS41 process which requires internal review and data owner approval to grant access to workers.

2. Do your systems currently include the security safeguards recommended in the initial 1561 standards?

a. If not, what are the barriers to inclusion of such safeguards?

Answer: The SAWS systems follow all applicable federal and state mandated security standards. For MEDS, data sent via FTP is encrypted and the department is going towards the use of all SFTP for data transmissions. Frequently data is encrypted when using SFTP to protect the data not only during transmission, but also at the point of rest allowing for the data to not be vulnerable when sitting in a file structure. Transaction logging of data captures key changes made to data and which user account accessed data. The reference in Section 5.2 of the initial 1561 standards which states "If third party access is allowed, access should be subject to the granting of separate authentication and/or login processes for third parties" needs clarification in order to determine if our systems currently include this recommended security safeguard.

b. Do your systems include any additional security safeguards? If so, what?

Answer: Printing of reports which used to be through Virtual Print Services (VPS) are being converted

over to SFTP. One challenge is not all counties can handle/accommodate SFTP so currently DHCS is working with specific counties that can accommodate this security enhancement.