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Report to Congressional Requesters

December 2014

MEDICAID

Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist

GAO-15-169

GAO Highlights

Highlights of GAO-15-169, a report to congressional requesters

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Why GAO Did This Study

Medicaid eligibility IT systems play a key role in states' efforts to coordinate eligibility and enrollment processes for Medicaid, the Children's Health Insurance Program, and health insurance exchanges, as required by the Patient Protection and Affordable Care Act (PPACA). However, many states' eligibility IT systems were outdated and lacked the technical capacity to support such efforts. CMS expanded the availability of a federal financial participation matching rate of 90 percent (90/10 funding) to states for costs associated with such IT system changes. With these funds, CMS required states to implement certain requirements—known as critical success factors—by October 1, 2013.

GAO was asked to provide information on states' receipt and use of these funds and related federal oversight. This report examines: (1) 90/10 funding states have spent on eligibility IT system changes; (2) states' use of this funding to implement critical success factors, and whether any implementation challenges remain; and (3) CMS's oversight of this funding and related system changes.

GAO analyzed state-reported expenditures of 90/10 funding from June 30, 2011, through September 30, 2014; interviewed state Medicaid officials from six states, which were selected from states reporting the most expenditures of 90/10 funding; reviewed relevant laws, regulations and CMS guidance; and interviewed CMS officials.

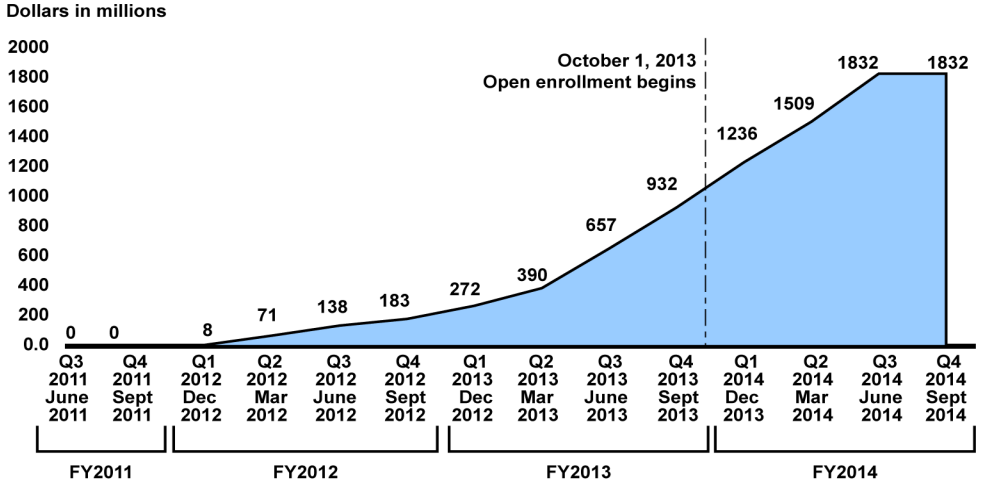
In responding to a draft of this report, HHS concurred with our findings and provided technical comments that were incorporated, as appropriate.

View GAO-15-169. For more information, contact Carolyn L. Yocom (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Reported spending across all 50 states and the District of Columbia totaled more than $1.8 billion for Medicaid 90/10 funds—funds for eligibility information technology (IT) system changes—through September 30, 2014. Spending has grown steadily, with the most significant increases over the most recent quarters. According to the Centers for Medicare & Medicaid Services (CMS), 34 states used 90/10 funds to implement full system replacements of their eligibility systems, while 17 states used these funds to implement modifications to their existing systems.

State Reported Cumulative Spending of 90/10 Funds by Quarter, Fiscal Years 2011 through 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-169

Note: GAO reviewed states' reported expenditures beginning with the quarter ending June 30, 2011, because this was the first quarter for which 90/10 funds were available to states. Three states had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014. States may adjust prior quarter spending on the CMS-64 for up to 2 years after the expenditure was initially reported, but such adjustments must be reported in the quarter that the correction is made. Quarterly reported expenditures are rounded to the nearest million.

Using alternative approaches that reflected unique program aspects, selected states reported implementing most factors identified by CMS as being critical to enrolling individuals by October 1, 2013. However, the requirement that states transfer—send and receive—applications with the federally facilitated exchange (FFE) was the most challenging factor for states to implement, and none of the 36 states using the FFE was able to do so by October 1, 2013. One year later, 4 states remained unable to transfer applications one or both ways, but CMS continues to work with them to ensure implementation as soon as possible.

CMS modified its existing oversight to expedite states' access to these 90/10 funds and to enhance its review of state spending. CMS also followed a new practice for incrementally reviewing IT system changes. While selected states were not always clear on new requirements under the framework, they appreciated such timely reviews, enabling them to make technical changes throughout the process.

Contents

Abbreviations

APD	Advance Planning Documents
CALT	Collaborative Application Lifecycle Tool
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
FFE	Federally Facilitated Exchange
FFP	federal financial participation
FPL	federal poverty level
IT	information technology
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MMIS	Medicaid Management Information System
PPACA	Patient Protection and Affordable Care Act

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December 12, 2014

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Brett Guthrie
House of Representatives

Enrollment in Medicaid, the joint federal-state program that finances health insurance coverage for certain categories of low-income individuals, is growing and likely will continue to do so—particularly within states that choose to expand Medicaid eligibility in response to the Patient Protection and Affordable Care Act (PPACA).[1] The Congressional Budget Office estimated that, as a result of PPACA, 12 million additional people could be enrolled in Medicaid and the Children's Health Insurance Program (CHIP) by 2016.[2] PPACA also required the establishment of a coordinated eligibility and enrollment process for Medicaid, CHIP, and the health insurance exchanges, including any income-based subsidies

[1]Medicaid serves certain categories of low-income individuals, such as children, pregnant women, parents, persons with disabilities, and persons aged 65 and older. As of January 1, 2014, PPACA allowed states to expand eligibility for Medicaid to most non-elderly, non-pregnant adults who are not eligible for Medicare and whose income is at or below 133 percent of the federal poverty level (FPL). Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010). For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, we consider the District of Columbia as a state.

[2]CHIP is a federal-state program that finances health insurance for children whose household incomes exceed limits for Medicaid eligibility. Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C.: April 2014).

available through the exchanges.[3] This coordinated process is referred to as the "no wrong door" policy. To implement this process, states were required to develop the information technology (IT) systems that allow for the exchange of data, which ensures that applicants are enrolled in the program for which they are eligible, regardless of the program for which they applied. While states' Medicaid eligibility IT systems play a key role in processing the influx of new Medicaid enrollees and ensuring enrollment coordination, many states' systems are antiquated and based on outdated technology with limited technical and functional capacity to support the streamlined processes called for in PPACA.[4]

Recognizing the challenges that states may face in updating their Medicaid eligibility IT systems, the Centers for Medicare & Medicaid Services (CMS) expanded the availability of an enhanced federal financial participation (FFP) matching rate of 90 percent to states' expenditures related to the design, development, and installation of new or improved Medicaid eligibility IT systems that are incurred from April, 19, 2011, through December 31, 2015.[5] For the purposes of this report, we use the

[3]PPACA required the establishment of health insurance exchanges in each state by January 1, 2014, to allow consumers to compare individual health insurance options available in that state and enroll in coverage. In states electing not to operate their own state-based exchange, PPACA requires the federal government to establish and operate an exchange in the state, referred to as the Federally Facilitated Exchange (FFE). State-based exchanges and FFEs are also referred to as marketplaces. The Secretary of the Department of Health and Human Services (HHS) was required to establish, and states must participate in, a system that ensures that individuals are enrolled in the program for which they are eligible. Pub. L. No. 111-148, §§ 1311, 1321, 1413(a), 124 Stat. 119, 173, 186, 233.

[4]See State Health Access Data Assistance Center, *State Health Access Program State Medicaid Eligibility System Survey: Report on the Modernization of State Medicaid Eligibility Systems*, (Minneapolis, MN: June 2012), which notes that many states rely on dated legacy systems and that many of the oldest systems have been significantly modified with little capacity for further updates, which are time consuming and expensive to implement in mainframe environments.

[5]Under federal law, states (including territories and the District of Columbia) are eligible for a 90 percent federal match for the design, development or installation of Medicaid claims processing and information retrieval systems, meaning that for each dollar a state spends on Medicaid eligibility IT system changes, the federal government pays $0.90. Ongoing maintenance of these systems is eligible for a 75 percent federal match. 42 U.S.C. § 1396b(a)(3)(A)(i), (B). Although historically, CMS had limited this enhanced federal matching rate to Medicaid claims processing systems, in 2011, the agency allowed states to receive this enhanced rate for changes to their Medicaid eligibility IT systems. 76 Fed. Reg. 21950 (Apr. 19, 2011).

term “90/10 funding” to refer to total spending on Medicaid eligibility IT systems; specifically, the 90 percent federal match associated with the 10 percent state share. The availability of 90/10 funding—as well as the need to change Medicaid IT systems to comply with PPACA—has sparked significant changes to eligibility IT systems nationwide.[6] While states can use this funding to support a wide range of IT system changes, CMS specified certain functions—termed “critical success factors”—that it required states to implement. These critical success factors, which were expected to be in place by the beginning of the initial open enrollment period for the exchanges on October 1, 2013, included state Medicaid IT systems being able to accept a single streamlined application, convert existing state Medicaid income standards to Modified Adjusted Gross Income (MAGI),[7] and coordinate with the exchanges, as applicable.[8]

You asked us to provide information on the extent to which states have obtained such enhanced federal funding for Medicaid eligibility IT system improvements, how the funds have been used in the states, and the federal role in assessing the availability and use of these funds. In this report, we examine (1) how much 90/10 funding states have spent on Medicaid eligibility IT system changes; (2) how states have used 90/10 funding to implement the critical success factors, and whether any implementation challenges remain; and (3) how CMS oversees states’ use of 90/10 funding, including for implementation of system changes.

[6]For purposes of this report, we consider changes to include state efforts to design, develop, or install new IT systems, including the implementation of new functionality within their respective systems.

[7]Section 2002(a) of PPACA requires states to determine income eligibility for Medicaid using MAGI, which is a uniform, tax-based definition of income. Certain groups of individuals are exempt from MAGI, such as individuals who qualify for Medicaid on the basis of being aged, blind, or disabled. See 42 U.S.C. § 1396a(e)(14).

[8]CMS specified seven critical success factors relating to state system capability to (1) accept a streamlined application; (2) verify eligibility based on electronic data sources; (3) convert existing income standards to use MAGI standards; (4) process applications based on MAGI; (5) convey state-specific eligibility rules to the FFE; (6) respond to inquiries from the FFE on current Medicaid or CHIP coverage, as applicable; and (7) transfer applications to and from the FFE, as applicable. The latter three factors only apply to states using the FFE. For the purpose of this study, we combined two factors related to implementing and applying the MAGI criteria, and excluded the factor related to states’ ability to convey specific eligibility rules to the FFE, because implementation of this factor does not involve an IT system change.

To examine how much 90/10 funding states have spent on Medicaid eligibility IT system changes, we analyzed state-reported Medicaid expenditure data from the CMS-64—a form that states complete quarterly to obtain federal reimbursement for services provided or administrative costs incurred under the Medicaid program. We reviewed states' reported expenditures for the quarter ending June 30, 2011, the first quarter for which 90/10 funds were available to states, through the quarter ending September 30, 2014. Three states had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014.[9] We also interviewed CMS officials and obtained information from CMS on the scope of IT system changes being undertaken by states. To determine the reliability of the CMS-64 data, we interviewed CMS officials and reviewed related documentation describing how these data are collected and processed, and examined other research that has used these data to report state expenditures. We also discussed these data and their limitations, as well as agency efforts to improve state reporting with CMS officials.[10] We determined that the data we used in this report were sufficiently reliable for the purposes of our engagement.

To examine how states have used 90/10 funding to implement the critical success factors and whether challenges remain, we interviewed state Medicaid officials from six states, which were selected from among those reporting the most expenditures of 90/10 funding. These states, which represented more than a third of all reported 90/10 funding expenditures through September 2014, were selected for geographic diversity and to represent a range in terms of the age of their eligibility systems, as well as their approach to using the Federally Facilitated Exchange (FFE) or

[9]The three states that had not reported finalized spending amounts for the quarter ending June 30, 2014, were North Dakota, Oregon, and Washington. States submit all Medicaid data electronically and must attest to their completeness and accuracy. These data are preliminary in nature, in that they are subject to further review, and are likely to be updated as states have up to 2 years after incurring costs to submit claims for 90/10 funding.

[10]Our prior work related to state reporting on the CMS-64 noted that reviewed states did not correctly report program integrity-related overpayments collected by the state on the CMS-64. See GAO, *Medicaid: CMS Should Ensure That States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

establishing a state-based exchange.[11] The selected states were Hawaii, Kansas, Minnesota, New Mexico, North Carolina, and Pennsylvania. In each of these states, we reviewed state or federal documentation of IT system changes related to the applicable critical success factors and reviewed related CMS correspondence. For the three critical success factors that applied to all states, our review was limited to the selected states because consistent national data were not available.[12] However, for the remaining two critical success factors that only apply to states using the FFE, CMS had data for all such states that specified their implementation dates.[13] Thus, our findings related to these two critical success factors provide a national view of implementation efforts for states using the FFE.

To examine how CMS oversees states' use of 90/10 funding, we interviewed CMS officials about the agency's oversight of state Medicaid expenditures and eligibility IT system changes, including its new Enterprise Life Cycle process, which the agency developed to oversee states' implementation of certain IT initiatives. We also examined how the agency's review of the 90/10 funding varies from its historical oversight of IT changes to the Medicaid Management Information System (MMIS). We also reviewed documents for our selected states that were available on CMS's Collaborative Application Lifecycle Tool (CALT), which is an electronic repository to which states can store and share documents supporting the implementation of their Medicaid IT system changes, among other purposes. The CALT also includes planning documents for all states and related CMS approval documents. We interviewed state and CMS officials about the documents available on CALT, and reviewed

[11]Under PPACA, states could choose their approach for establishing exchanges. Whatever approach states implemented, the initial open enrollment period for coverage in the exchanges began on October 1, 2013, with coverage effective on January 1, 2014. At that time, 19 states operated their own state based exchange, 25 states used the FFE, and 7 states used a hybrid partnership model in which the state operated certain FFE functions.

[12]The three critical success factors that apply to all states are the abilities to accept a streamlined application, verify eligibility based on electronic data sources, and convert existing income standards to MAGI.

[13]The two additional critical success factors that apply to states using the FFE are the abilities to respond to inquiries from the FFE on current Medicaid or CHIP coverage, and to transfer applications to and from the FFE.

relevant federal laws, and CMS regulations and guidance issued to facilitate state implementation of system changes.

We conducted this performance audit from December 2013 through December 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Under federal law, states are eligible for an enhanced federal matching rate of 90 percent for the design, development, or installation of Medicaid claims processing and information retrieval systems.[14] Historically, CMS had allowed states to claim this 90 percent matching rate for the design, development, or installation of system changes to MMIS, which includes Medicaid claims processing, among other things, but such a match was not available for Medicaid eligibility IT systems changes. However, in 2011, CMS extended the availability of the 90 percent matching rate for changes to Medicaid eligibility IT systems,[15] which includes undertaking efforts to implement the "no wrong door" policy. Under this policy, individuals can apply for health coverage through an exchange or a state's Medicaid agency, and regardless of which "door" they choose, their eligibility will be determined for coverage under Medicaid, CHIP, or the exchange, including any income-based subsidies available through the exchange. To this end, applications are then to be routed to the program for which the individual is eligible. Along with the "no wrong door" policy, CMS envisioned streamlined enrollment processes that include the real-time transfer of applications between state Medicaid agencies and

[14]42 U.S.C. § 1396b(a)(3)(A)(i). States may also qualify for a 75 percent matching rate for the operation of these systems. See 42 U.S.C. § 1396b(a)(3)(B).

[15]Federal regulations provide that FFP is available at 90 percent of a state's expenditures for the design, development, installation, or enhancement of an eligibility determination system that meets the requirements specified in the regulation, and only for costs incurred for goods and services provided on or after April 19, 2011, and on or before December 31, 2015. 42 C.F.R. § 433.112(c).

the FFE, and immediate eligibility determinations.[16] States are eligible to use 90/10 funding for changes they make to their Medicaid IT systems regardless of whether they are operating their own exchanges or using the FFE. States may also receive a 75 percent matching rate for the maintenance and any ongoing costs of operating an upgraded Medicaid eligibility system. The 75 percent FFP is generally available when the Medicaid eligibility system changes become operational, and unlike 90/10 funding, does not expire.[17]

To access 90/10 funding, states must first submit advanced planning documents (APDs) to CMS—the federal agency that oversees the Medicaid program and provides guidance and technical assistance to states related to Medicaid eligibility system changes.[18] CMS reviews the APDs to ensure that certain technical and operational criteria are met before states are eligible for 90/10 funding. To receive CMS approval, states must develop IT systems that meet technical standards and conditions, which require states to develop IT systems that are flexible, advance the Medicaid Information Technology Architecture principles,

[16]CMS issued guidance envisioning that state systems would provide multiple channels to apply for coverage and an interactive customer experience that maximizes automation and real-time adjudication of eligibility, among other things. See Department of Health and Human Services, CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, Version 2.0 (Baltimore, MD: May 2011).

[17]Beginning April 19, 2011, an enhanced FFP of 75 percent is available for expenditures related to the operation of an upgraded eligibility determination system that meets applicable standards and conditions. States may continue to receive this enhanced match only if the system meets such standards and conditions by December 31. 2015. See 42 C.F.R. § 433.116(j).

[18]States must follow an APD process in seeking approval for FFP for the costs of acquiring automated data processing equipment and services. See 45 C.F.R. Part 95, Subpart F. CMS reviews states' APDs for the scope of work, budget, and cost allocations for all IT projects. CMS also reviews requests for proposals that states issue, as well as contracts that states enter into with contractors retained to implement or support these IT tasks.

and promote data exchanges and the reuse of Medicaid technologies across systems and states, among other things.[19]

In addition to these technical requirements, CMS specified operational requirements—known as critical success factors—to help states prioritize the many changes that they were making to their eligibility systems to comply with PPACA. Due to differences among states in their approaches to establishing an exchange, not all states needed to implement all critical success factors. For example, states running their own exchanges would not need to implement the factor relating to sending and receiving applications to and from the FFE. That particular factor would only apply to the states that were using the FFE. (See table 1.)

[19]Medicaid Information Technology Architecture is an HHS IT initiative, which began in 2005, and aims to stimulate an integrated business and IT transformation affecting Medicaid programs in all states by establishing national guidelines for technologies, information, and processes, among other efforts. For more information about these technical requirements, which were beyond the scope of this report, see Department of Health and Human Services, CMS, *Enhanced Funding Requirements: Seven Conditions and Standards*, Medicaid IT Supplement (MITS-11-01-v1.0), Version 1.0 (Baltimore, MD: April 2011).

Table 1: Selected Critical Success Factors for Medicaid Eligibility System Changes

Critical Success Factor	Description	Applicability
State Ability to:		
Accept a streamlined application	A single application that determines eligibility for enrollment in Medicaid, the Children's Health Insurance Program (CHIP), and the health plans offered through the federally facilitated exchange (FFE) or state-based exchanges, including any income-based subsides.[a]	All states
Verify eligibility based on electronic data sources, such as the federal data services hub	An electronic connection and near real-time access to the federal data and third party data sources to verify an applicant's eligibility for coverage.[b]	All states
Convert existing income standards to Modified Adjusted Gross Income (MAGI) and process Medicaid applications based on these rules	The capacity to convert Medicaid income eligibility standards that states had in place before the Patient Protection and Affordable Care Act (PPACA) to the new MAGI standards, and make eligibility determinations for certain populations accordingly.	All states
Respond to inquiries from the FFE on current Medicaid or CHIP coverage, as applicable.	An electronic service to respond to inquiries from the FFE on an applicant's current Medicaid or CHIP enrollment. This is referred to as the Minimum Essential Coverage (MEC) check.	States using the FFE
The ability to transfer applications to and from the FFE, as applicable.	A two-way electronic service supporting the "no wrong door" single point of application for health coverage whereby states send applications for private health coverage to the FFE and receive applications for Medicaid from the FFE.[c]	States using the FFE

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-15-169

Note: CMS specified seven critical success factors relating to state system capability to (1) accept a streamlined application; (2) verify eligibility based on electronic data sources; (3) convert existing income standards to MAGI; (4) process applications based on MAGI; (5) convey state-specific eligibility rules to the FFE; (6) respond to inquiries from the FFE on current Medicaid or CHIP coverage, as applicable; and (7) transfer applications to and from the FFE, as applicable. For the purpose of this study, we combined two factors related to implementing and applying the MAGI criteria, and excluded the factor related to states' ability to convey specific eligibility rules to the FFE, because implementation of this factor does not involve an IT system change.

[a]PPACA requires that the streamlined application request information necessary for determining eligibility for Medicaid, CHIP, and exchange plans, including certain income-based subsidies authorized by PPACA to make coverage purchased through the exchange more affordable for certain low- and moderate-income applicants. The income-based subsidies authorized by PPACA are (1) a refundable tax credit, generally paid on an advance basis, to reduce premium costs for marketplace coverage (referred to as premium tax credits); and (2) reductions in cost-sharing associated with such coverage (known as cost-sharing reductions) for items such as co-payments for physician visits or prescription drugs. States must adjust their eligibility systems to apply the streamlined application to all channels that an applicant could pursue for Medicaid coverage, such as online, in-person, or on the phone.

[b]States may connect directly to the federal data services hub, which includes links to the Social Security Administration, the Internal Revenue Service, and the Department of Homeland Security, among other federal data sources, or rely on existing state connections to federal data sources or state specific data, such as state tax records or unemployment information.

[c]In order for states to implement this critical success factor, two connections must be established to transfer application information—one connection is to the FFE from the state Medicaid agency, and the second connection is to the state Medicaid agency from the FFE. Additionally, this factor aims to establish real time eligibility determinations once the application is forwarded to the appropriate program.

To claim the federal share of state costs for these eligibility system changes, states report their expenditures on the form CMS-64, which states complete quarterly to obtain federal reimbursement for services or administrative costs under the Medicaid program.[20] State Medicaid agencies submit expenditure information 30 days after a quarter has ended, and CMS reviews these submissions to authorize and compute the applicable federal share of expenditures claimed. Even after reporting, states are permitted to adjust previously reported expenditures on the CMS-64 for up to 2 years from the quarter of their initial reporting. Any adjustments that a state makes will appear in the quarter in which the state made it, but will not be applied retroactively to the state's initial report.

Nationally, States Reported Spending More Than $1.8 Billion to Replace or Modify Medicaid Eligibility It Systems

Reported spending of 90/10 funding across all 50 states and the District of Columbia totaled more than $1.8 billion for Medicaid eligibility IT system changes as of September 30, 2014, with the federal government contributing more than $1.6 billion and states contributing about $200 million.[21] Over three quarters of states' reported spending of 90/10 funding—$1.4 billion—was for contractors selected by states to implement changes to their eligibility IT systems.[22] Although 90/10 funding was available to states beginning in April 2011, only 2 states reported spending funds on Medicaid eligibility IT system changes by September 30, 2011. Over the next year, however, the number of states reporting such spending increased dramatically; and by March 2014, all 50 states and the District of Columbia had reported related spending.[23] Similarly, the amount of spending reported for each quarter has also grown steadily, with the most significant increases reported over the most

[20]States report 90/10 funding on the CMS-64, which is called the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The CMS-64 aggregates states' expenditures and is used to reimburse states for their federal share of Medicaid expenditures. The information is stored in a data set called the Medicaid Budget and Expenditure System.

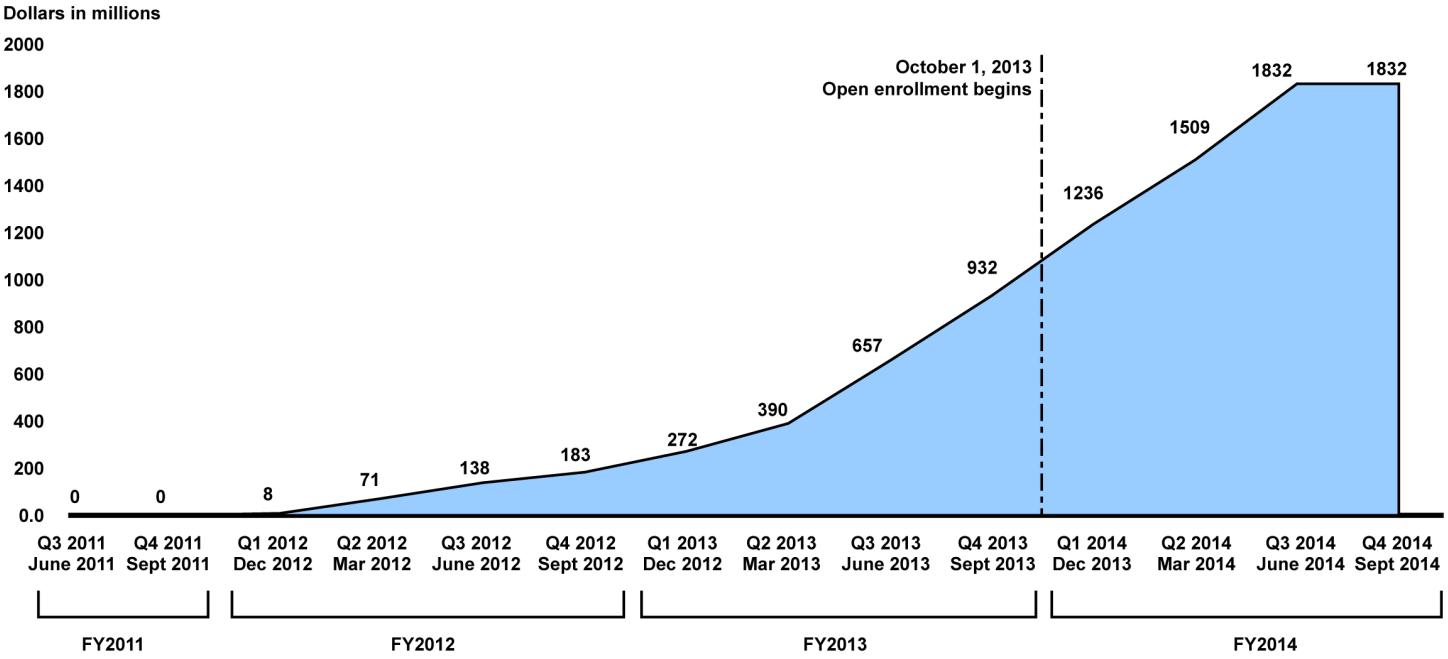
[21]Three states had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014.

[22]Two firms received more than 63 percent of the total 90/10 funding states reported spending on contractors.

[23]The Virgin Islands was the only territory to report spending on Medicaid eligibility IT system changes during this time period, which totaled $465,549.

recent quarters. (See fig. 1.) Appendix I includes information on 90/10 funding by state.

Figure 1: State Reported Cumulative Spending of 90/10 Funds by Quarter, Fiscal Years 2011 through 2014



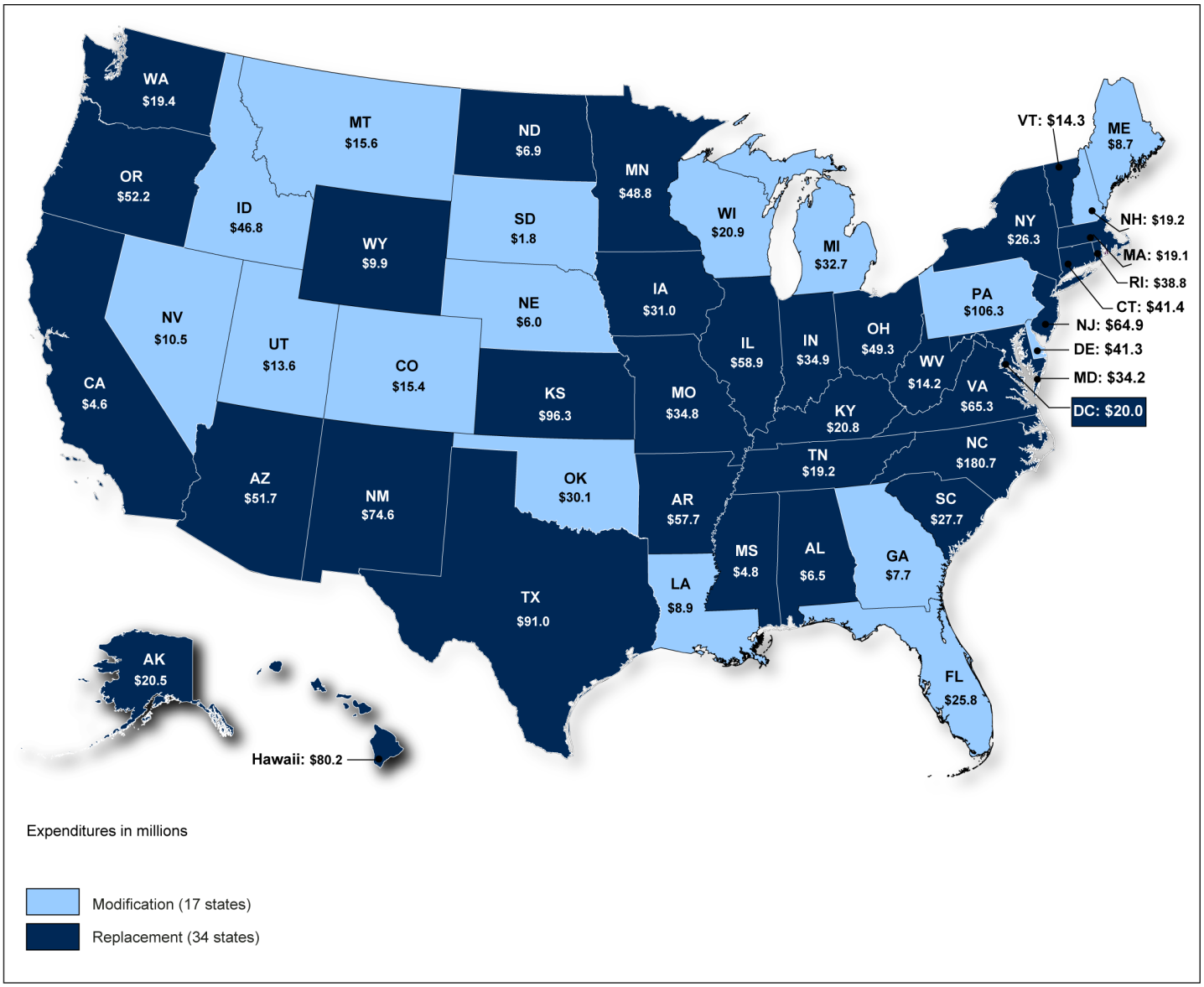
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-169

Note: We reviewed states' reported expenditures beginning with the quarter ending June 30, 2011, because this was the first quarter for which 90/10 funds were available to states. Three states had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014. States may adjust prior quarter spending on the CMS-64 for up to 2 years after the expenditure was initially reported, and such adjustments must be reported in the quarter that the correction is made. Quarterly reported expenditures are rounded to the nearest million.

Across the country, states' changes to Medicaid eligibility IT systems ranged from full system replacements to more limited modifications, with the scope of a state's changes dependent on a number of factors, including the age of their system and the extent of integration among state programs. According to CMS, 34 states implemented full system replacements, while 17 states implemented system modifications. State-reported spending of 90/10 funding varied widely, ranging from $1.8 million in South Dakota to $180 million in North Carolina, as of June 30, 2014. (See fig. 2.) Although there were spending differences among individual states, the median amount spent on eligibility IT systems in states modifying their systems was about one half of the

median amount spent in states that were undertaking full system replacements during this time.

Figure 2: States' Reported Spending of 90/10 Funding and Efforts to Replace or Modify Medicaid Eligibility Systems, June 30, 2011, through September 30, 2014



Sources: Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-15-169

Note: We reviewed states' reported expenditures beginning with the quarter ending June 30, 2011, because this was the first quarter for which 90/10 funds were available to states. Three states had not

reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014.

Among the six states we reviewed, the prior Medicaid eligibility IT systems in five of the states were 20 to 30 years old, and varied in terms of the extent of integration with other state programs and overall function, as illustrated by the following two examples.[24]

- North Carolina's prior Medicaid eligibility IT system was a state-based system that was over 30 years old, and was used to determine eligibility and process enrollment for 17 programs run by the state's Department of Health and Human Services, according to state officials. The state had begun development of a new integrated IT system in 2009, and was continuing to work on its implementation when 90/10 funding became available.
- Hawaii's Medicaid eligibility IT system was a state-wide system that was over 25 years old, and was also used to determine eligibility for the Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, and other human service programs, according to state officials. However, the state separately contracted with the Arizona Medicaid program to conduct program enrollment activities, and Hawaii officials noted that they expected this arrangement to continue for the foreseeable future. The state officials added that Hawaii had needed a new eligibility IT system for quite some time, but was not able to pursue IT improvements until 90/10 funding became available.

Differences in state-reported spending could reflect other factors, such as a state's readiness to implement a new eligibility IT system. For example, two states we reviewed—New Mexico and North Carolina—were able to obtain approval and claim expenditures for 90/10 funding soon after it became available, because they were already working on eligibility IT system improvements.

As previously noted, states' spending on the maintenance and operation of these new systems is eligible for a federal match of 75 percent. Through September 30, 2014, 27 states reported spending an additional $205 million on maintenance and operation activities, about 79 percent of

[24]According to CMS, Pennsylvania is the only state we reviewed that was modifying its system. The state began implementing an integrated Medicaid eligibility system in 2001.

which was paid to contractors.[25] Appendix I also contains information on state spending for maintenance and operation costs.

Selected States Used Alternative Approaches to Implement Most Critical Success Factors; but Challenges Transferring Applications Persist Among States Using the FFE

Selected states implemented most of the critical success factors using alternative approaches, which often reflected unique program aspects. However, all states using the FFE faced challenges transferring applications to and from the FFE, and those challenges contributed to enrollment delays.

Selected States Met Most Critical Success Factors, Often by Using Alternative Approaches

Officials from the selected states reported that they were largely able to implement three critical success factors that applied to all states—the abilities to (1) accept a single, streamlined application; (2) verify applicant eligibility based on electronic data sources, such as the federal data services hub; and (3) convert existing income standards to MAGI, and process Medicaid applications based on these rules—by the beginning of the initial open enrollment period, October 1, 2013. The six states we reviewed often used alternative approaches, which CMS approved, to implement each of these three critical success factors. (See table 2.)

[25]Three states had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014.

Table 2: Selected States' Use of Approved Approaches to Meet Three Critical Success Factors

	Critical success factors					
	Acceptance of a single, streamlined application		Verification of applicant eligibility with electronic data sources		Conversion to and application of MAGI criteria	
State	Modified federal model application	Developed alternative application	Primarily used federal data services hub	Used state verification alternative	Used federal MAGI in cloud	Used state modified eligibility systems
Hawaii	✓		✓			✓
Kansas		✓		✓[a]	✓	
Minnesota	✓		✓[b]			✓
New Mexico		✓		✓		✓
North Carolina		✓		✓		✓
Pennsylvania		✓	✓[c]			✓

Source: Selected states and the Centers for Medicare & Medicaid Services (CMS). | GAO-15-169

Notes: States were selected from those reporting the most expenditures of 90/10 funding—representing about one third of all reported 90/10 funding expenditures through September 2014. This table focuses on three critical success factors from the seven factors that CMS specified. The seven factors are: (1) accept a streamlined application; (2) verify eligibility based on electronic data sources; (3) convert existing income standards to Modified Adjusted Gross Income (MAGI); (4) process applications based on MAGI; (5) convey state-specific eligibility rules to the Federally Facilitated Exchange (FFE); (6) respond to inquiries from the FFE on current Medicaid or CHIP coverage, as applicable; and (7) send and accept applications to and from the FFE, as applicable.

[a]Kansas officials noted that the state was using its own data sources to determine Medicaid eligibility, but indicated that when the state's new eligibility and enrollment system—called the Kansas Eligibility Enforcement System—becomes operational, which they expected to occur in November 2014, the state will rely on both the federal data services hub and state sources for verification efforts.

[b]Minnesota officials noted that the state relies primarily on the federal data services hub, but supplements this information with state data sources, including quarterly wage data from the state's Department of Employment and Economic Development.

[c]Pennsylvania officials reported that the state relies primarily on the federal data services hub for citizenship and identity verification, but uses a state source with more recent income data to verify an applicant's income.

In some states, the use of these alternative approaches reflected unique program aspects of states' Medicaid programs or IT systems, as illustrated by the following examples.

- To implement the factor related to accepting a single, streamlined application, four states we reviewed (Kansas, New Mexico, North Carolina, and Pennsylvania) developed alternative applications that

were tailored to their specific programs.[26] In particular, New Mexico developed an alternative application to reflect the integration of its Medicaid eligibility and enrollment system with its Supplemental Food and Nutrition Program and its Temporary Assistance to Needy Families program, according to state officials.

- For the critical success factor relating to verifying applicant income, three states we reviewed (Kansas, New Mexico, and North Carolina) used existing state sources to verify applicant eligibility instead of relying on the federal data services hub.[27] In North Carolina, for example, officials indicated that the state received approval for an alternative to the hub, and chose to rely on its existing link to the Social Security Administration, as well as other sources for verification.

- For the critical success factor relating to MAGI criteria, five states we reviewed opted to convert their eligibility rule systems to MAGI, and one state—Kansas—opted instead to use CMS's MAGI-in-the-Cloud to determine eligibility because its new eligibility system, the Kansas Eligibility Enforcement System, is not expected to be operational until November 2014, according to state officials.[28]

[26]States using the federal model application developed by HHS were permitted to modify it to reflect unique program aspects. For example, Minnesota's Medicaid program exempts certain members of the military from paying monthly premiums, so the state added a question to the model application to identify those members. Similarly, Hawaii officials indicated that they modified the model application to include a question about whether the applicant was requesting retroactive coverage for up to 10 days, which is allowed under its program.

[27]Even states that primarily rely on the federal data services hub for verifications are permitted to supplement the verification using state sources. Officials from Minnesota and Pennsylvania noted that their states rely primarily on the federal data services hub for eligibility verification; however, they use state data sources for income verification instead because they believe these data are timelier.

[28]MAGI-in-the-Cloud is a web-based tool developed by HHS to determine Medicaid and CHIP eligibility, primarily for states using the FFE. While CMS promoted this tool as a resource for all states, only two states—Kansas and North Dakota—used MAGI-in-the-Cloud to determine eligibility while their own systems were under development. According to CMS officials, MAGI-in-the-Cloud could also be used as a quality assurance tool to ensure that state IT systems are applying the MAGI criteria correctly, or as a resource for case workers to quickly screen applicants for eligibility.

States Using the FFE Experienced Challenges Transferring Applications, Which Contributed to Enrollment Delays

The remaining two critical success factors—the minimum essential coverage (MEC) check and the application transfer function—apply to the 36 states using the FFE and involve transmitting information between state and federal data sources, which we refer to as IT connections. For the MEC check, states' Medicaid IT systems were to respond to electronic inquiries from the FFE on applicants' current Medicaid or CHIP coverage, a one-way transmission of information from the FFE to the state. While none of the 36 states using the FFE was able to establish this connection by the first day of the initial open enrollment period, 22 states were able to do so at some point in October 2013, and were joined by another 3 states by the end of December 2013.[29] The experiences in our selected states largely mirrored the experiences of states nationally. For the 4 states using the FFE that we reviewed, Pennsylvania implemented the MEC check by October 6, 2013, while North Carolina and New Mexico implemented this critical success factor on November 12, 2013, and January 16, 2014, respectively. Kansas had not implemented the MEC check as of October 2014. Officials in some of the states we reviewed cited the complexity of establishing the IT connection as contributing to initial delays in implementation.

The application transfer critical success factor—which required the establishment of two IT connections: one connection to transfer applications found ineligible for Medicaid coverage from the state Medicaid agency to the FFE, and another connection to transfer applications found ineligible for FFE coverage from the FFE to the state Medicaid agency—was the most difficult for states to implement.[30] Similar to the MEC check, none of the 36 states using the FFE was able to transfer applications by October 1, 2013.[31] Specifically, November 2013 was the first month that any state was able to send applications to the

[29]Among the remaining 11 states, 5 implemented the factor by May 2014, and 6—Alaska, Kansas, Maine, New Jersey, Tennessee, and Wyoming—-remained unable to do so as of October 2014.

[30]Because states typically had different dates in which they were able to implement each connection, we discuss states' abilities to send applications to the FFE or receive applications from the FFE separately. Collectively, we refer to sending and receiving as "transferring applications" or "application transfers."

[31]Our analysis relied on dates that the states implemented final technical requirements issued by CMS. However, following draft technical requirements, two states—Montana and Virginia—came close to meeting the requirement by sending applications to the FFE on October 2, 2013.

FFE, with 7 states doing so; an additional 23 states began to send applications to the FFE during the subsequent 5 months. States also gradually began receiving applications from the FFE, with the first states doing so in December 2013, and implementation in the remaining states generally occurring by the end of April 2014. However, nearly a year after the initial open enrollment period, a handful of states remain unable to transfer applications.[32] (See fig. 3.) CMS officials noted that they continue to work with these states to ensure implementation as soon as possible. However, the capability to conduct real time application transfers for immediate eligibility determinations remains elusive in all states. While a CMS official acknowledged that real time application transfers continue to be a goal, he does not anticipate this occurring until 2015 or 2016, given variability in states' abilities.[33]

[32]As of October 2014, Kansas, New Jersey, North Dakota, and Tennessee could not send applications to the FFE, while New Jersey could not receive applications from the FFE.

[33]A CMS official noted that for most states, the ability to achieve a real time transfer will not be possible for years. However, the official noted that some states are closer to this goal, citing Montana where it takes 15 minutes for applications to be transferred in either direction.

Figure 3: Gradual Implementation of Application Transfer Function among 36 States Using the Federal Facilitated Exchange (FFE)

	Ability to send applications to the FFE	Ability to receive Medicaid applications from the FFE
October 2013		
November 2013	● ● ● ● ● ▨ ▨ (7)	
December 2013	● ● ● ● ● ● ● ● ● ● ▨ (11)	● ● ● ● ● ● ● ● ● ● ▨ ▨ (12)
January 2014	● ● ● ● (4)	● ● ● ● ● ● ● ● ● ▨ (10)
February 2014	● ● ● (3)	● ● ● ● ● ● (6)
March 2014	● ● (2)	● ● (2)
April 2014	● ● ● (3)	● ● (2)
May 2014		
June 2014	● (1)	● (1)
July 2014		● (1)
August 2014	● (1)	
September 2014		
October 2014	○ ○ ○ ▨ (4)	▨ ○ (2)

● State able to implement activity
○ State unable to implement activity
▨ Sample state in GAO review able to implement activity
▨ Sample state in GAO review unable to implement activity

Source: GAO analysis of Centers for Medicare & Medicaid Services data as of October 2014. | GAO-15-169

Note: As of October 2014, of the 36 states using the Federally Facilitated Exchange (FFE), 1 state could neither send nor receive, and 3 states could not send applications to the FFE. The number of states able or unable to send and/or receive applications appears in parentheses at the end of each row.

Some of the states that we reviewed cited evolving technical requirements from CMS as a challenge to their initial efforts to implement this critical success factor. For example, CMS issued the initial technical requirements for application transfers in April 2013 and then final requirements two months later—about three months before the open enrollment period.[34] Since CMS's technical requirements involve thousands of lines of code, a CMS official acknowledged that changes to the initial requirements created additional work for states that were following them. A New Mexico official indicated that the state made some initial assumptions in developing its system that later needed modifying once CMS issued final requirements. A CMS official noted variation in states' abilities to make such adjustments in a timely manner and that some states began incorporating the initial requirements into their systems, while other states purposely waited for the final requirements.[35]

The delay in FFE readiness to transfer applications to and from the states further complicated efforts to implement this critical success factor. A CMS official acknowledged that the FFE was not ready to send or receive applications when open enrollment began. CMS was first able to receive applications from states in mid-October 2013 and to send applications to states in November 2013. The official also indicated that some states' systems were not ready to receive applications despite successful testing of their systems. In such cases, the agency worked with states to send applications to them incrementally until their systems were working properly and were able to receive greater numbers of applications.

Because states were not able to transfer applications in time for open enrollment, CMS provided states with a subset of the information from the applications submitted to the FFE in a simple excel spreadsheet, which they called a "flat file," beginning on October 16, 2013. While the flat file did not necessarily advance state efforts toward developing the IT

[34]A CMS official noted that based on state input, the final version of the requirements relaxed some of the data fields to improve the efficiencies for both the state and federal systems and did require code changes. Our recent work on CMS's contract management for the FFE found that changing agency requirements drove cost increases and rework in the first two years of the development of the FFE. See GAO, *HEALTHCARE.GOV: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management*; GAO-14-694 (Washington, D.C.: July 30, 2014).

[35]The official added that the time states needed to make these changes ranged from 48 hours to a few weeks.

connections needed to transfer applications, it did provide states with a sense of the volume of applications they would receive from the FFE, and allowed them to reach out to potentially eligible individuals to encourage them to apply directly to the state's Medicaid office. Officials in some of the states we reviewed, including New Mexico and Pennsylvania, did not find the flat file useful in identifying and enrolling eligible individuals, citing the limited information provided. However, CMS issued guidance on November 29, 2013, that gave states the option to obtain a waiver allowing them to enroll applicants into Medicaid using information from the flat file.[36] The states that we reviewed did not seek such a waiver; however, six other states using the FFE did seek waivers.[37]

For the estimated 2.9 million Medicaid applications waiting for processing in states cited in a June 2014 report, delayed implementation of the application transfer function—while not the sole factor behind delays—did have implications for enrollees' timely enrollment in Medicaid.[38] For example, Pennsylvania officials attributed some of its application backlog of 60,000 Medicaid applications in spring 2014 to delays in receiving applications from the FFE, but also noted other reasons, such as the state's process for non-MAGI applications received from the FFE, which may have required additional contact or verification by the state.[39] As another contributing factor to delayed enrollment, the initial open enrollment period saw a surge of Medicaid applicants seeking health insurance coverage, but the capacity of states to process this enrollment

[36]To enroll applicants from the flat file, states must request a waiver of section 1902(e)(14)(A) of the Social Security Act, which generally requires the use of the MAGI to determine Medicaid eligibility. Under this provision, CMS may grant waivers of Medicaid requirements "as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries." See 42 U.S.C. § 1396a(e)(14)(A); Department of Health and Human Services, CMS, Letter Re: *New Flexibility: Using Account Transfer Flat Files to Enroll Individuals in Medicaid and CHIP* (Baltimore, MD: Nov. 29, 2013).

[37]For example, Arkansas, Mississippi, Montana, New Jersey, North Dakota and Tennessee obtained waivers to enroll applicants directly into their Medicaid programs from information provided on the flat file.

[38]See the Robert Wood Johnson Foundation and the Urban Institute, *Measuring Medicaid/CHIP Enrollment Progress Under the Affordable Care Act* (Washington, D.C.: June 2014).

[39]States do not use MAGI income criteria to calculate Medicaid eligibility for certain Medicaid populations such as blind, disabled, medically needy, or individuals requesting coverage for long-term care services.

surge varied. Incomplete or inconsistent application data also affected states' ability to process applications in a timely manner. The officials from the sample states we interviewed that established state-based exchanges and were not using the FFE to transfer applications cited backlogs due to technology challenges, as well as the volume of applications received. For example, Minnesota officials attributed the state's backlog to initial technology issues with applications that were not correctly processed in the system and required manual processing. Similarly, Hawaii officials remarked that the backlog of applications at the beginning of the initial open enrollment period was due, in part, to the backlog that had existed in the previous legacy system.[40]

CMS Modified Existing Monitoring Practices and Added A New Framework to Oversee Spending of 90/10 Funding

CMS's oversight of states' use of 90/10 funding largely mirrored—but further modified—its existing oversight of states' MMIS IT changes, which are also eligible for a 90 percent federal match. For example, oversight of funding for changes to both Medicaid IT systems included agency review and approval of APDs,[41] requests for proposals, contracts with consulting firms, and CMS-64 data.[42] However, CMS often modified these activities in light of these compressed timeframes for states to implement their Medicaid eligibility system IT changes. Specifically, the 90/10 funding gave states less than 3 years—from April 2011 to October 2013—to implement the critical success factors. In contrast, states often take more than 5 years to complete the design and implementation of major changes to their MMIS IT systems.

Two activities that CMS modified to accommodate the compressed timeframes were methods used to review APDs and CMS-64 spending.

[40]Hawaii officials added that while it took the eligibility workers time initially to use the new eligibility system, the new functionality has substantially reduced the processing time for paper and on-line applications.

[41]To access 90/10 funding, states must first submit APDs to CMS. APDs are required for IT system projects and outline states' plans. APDs may vary by state; however, for all states, CMS requires information to evaluate state goals, its procurement approach, and the cost allocations within a specified budget. CMS reviews and approves APDs submitted by states at least annually, and evaluates whether the states' plans will meet specific IT standards.

[42]Similar to its oversight of MMIS IT changes, CMS also requires states to have Independent Verification and Validation contractors to evaluate and report on the correctness and quality of their eligibility IT systems projects to ensure that they comply with requirements and are well-engineered.

- **Expedited APD review**: CMS established an expedited APD review of 30 days rather than the 60 days allowed for MMIS APD reviews. According to CMS officials, the expedited review enabled states to access 90/10 funding more quickly, enabling them to issue RFPs for consulting firms that will plan and implement the new technology for Medicaid eligibility IT systems changes. CMS also provided states with an APD checklist to minimize requests for additional information, and streamlined its review and approval of RFPs and states' contracts with consulting firms.
- **Enhanced review of CMS-64**: CMS added new lines to the CMS-64 for states to separately report state and contractor expenditures for Medicaid eligibility IT system changes.[43] To provide more timely information on the amount of 90/10 funding that had been spent, CMS implemented a new financial management process in 2013 to monitor funding for Medicaid eligibility IT system changes each federal fiscal year. According to CMS officials, this effort aligned states' approved APD budgets with expenditure data in CMS's financial management system to ensure that states did not exceed the amounts they were approved for each fiscal year. If a state exceeded or did not spend its budgeted amount, CMS would adjust the approved amount of 90/10 funding for the following year.

In addition to modifying existing oversight practices, CMS followed new practices defined by its Enterprise Life Cycle framework to review the progress that states were making to implement Medicaid eligibility IT system changes, which focus on incremental reviews at distinct stages, or "gates." These practices differ from CMS's practice of certifying MMIS IT changes after the new system is operational for 60 days. To progress through each of the three gates (planning, design, and implementation), states were required to submit planning documents—known as artifacts—to CMS for approval. For example,

- to pass the planning gate, states provided the agency with finalized financial management and performance measurement plans;
- for the design gate, states submitted system design and change management plans; and

[43]CMS also added lines to the CMS-64 for states to report their in-house and contractors expenditures related to the operations and maintenance of their eligibility systems, which are eligible for a 75 percent federal match.

- for the implementation gate, states submitted a finalized information security risk assessment plan.

Depending on the scope of states' changes, the artifacts required by CMS varied. CMS developed templates for many of these artifacts to facilitate state development of them, and encouraged collaboration among states by making documents available through the new Internet-based repository known as the CALT. CMS intended this tool to be a vehicle for collaboration among states, allowing them to share source code and other information and make use of others' approaches as a model for their own implementation. While Minnesota officials found that the CALT fulfilled this purpose by assisting them in connecting with other states using the same contractor, half the states we reviewed found it unwieldy and difficult to navigate.

As a final step in the implementation gate, CMS conducted an operational readiness review wherein states demonstrated their new eligibility IT systems and readiness to implement the critical success factors. Based on these readiness reviews, CMS either approved the state's system or granted a conditional approval pending additional state action. In some states, CMS held more than one operational readiness review reflecting the phased approach some states took to implement system changes. For example, because New Mexico implemented its integrated eligibility system in phases, CMS held two operational readiness reviews for the state and granted conditional approval after the first review, requiring the state to conduct further testing on its application transfer function. While this incremental review facilitated implementation and reflected unique circumstances of states' Medicaid programs, our prior work that focused on the development of the FFE found that partial CMS reviews of system changes did not ensure that required approvals occurred in a timely fashion.[44]

State officials also identified challenges they experienced with aspects of this new oversight framework, which were often exacerbated due to the compressed timeframes that states had to implement the IT system changes. For example, officials from Pennsylvania said that they received

[44]A recent GAO report on the development of the FFE raised concerns about CMS's use of a partial operational readiness review in the development and testing of the FFE. We reported that CMS launched the FFE system without the required verification that it had met performance requirements. See GAO-14-649.

little feedback from CMS on their gate presentations despite significant time and resources that the state spent preparing for such gate reviews. According to Pennsylvania officials, the CMS contractors who participated in the gate reviews were unfamiliar with the state's IT system and thus were unable to provide the state with actionable feedback during the early gates reviews. Additionally, because the life cycle framework was a new approach, some states we reviewed did not fully understand the requirements. For example, New Mexico officials noted that they did not always know what was required at each gate and likened the process to "building a car as it is driving down the road."

Overall, however, CMS's new approach for reviewing IT systems through the Enterprise Life Cycle framework created some positive changes, according to CMS and state officials. For example, prior to the framework, CMS reviewed documents and monitored system functions after states had implemented their new systems. Under these circumstances, any deficiencies identified by CMS had to be adjusted before CMS would approve any ongoing funding for system maintenance. According to CMS and state officials, this retrospective review and certification was costly and time consuming because it occurred after the changed systems were operational.[45] Officials from both New Mexico and Kansas agreed and noted that the new gate review process allowed them to make technical changes throughout the process rather than at the end, allowing for improved project management. Officials from North Carolina, Kansas, and New Mexico also noted that these reviews largely mirrored their internal oversight processes, thus allowing them to use internal documents to meet certain federal requirements and minimize duplicate efforts.

Agency Comments

We provided a draft of this product to HHS for comment. In its written comments, reproduced in appendix II, HHS concurred with our findings and noted that supporting the Medicaid eligibility and enrollment process, as well as aiding IT changes in the states, continues to be among its ongoing priorities. The Department stated that 90/10 funding is an important federal investment to provide states the resources needed to

[45]CMS officials indicated that the agency has begun to incorporate many of these new oversight practices into its oversight of MMIS IT changes. For example, Iowa is piloting the use of the Enterprise Life Cycle framework, and CMS is beginning to require states to report this MMIS spending by fiscal year.

make the systems improvements envisioned by PPACA. The Department also highlighted actions it has undertaken to expedite states' access to 90/10 funding and to enhance its review of related state spending, among other activities. In addition, HHS provided technical comments that were incorporated, as appropriate.

We are sending a copy of this report to the Secretary of Health and Human Services. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Carolyn L. Yocom
Director, Health Care

Appendix I: Total State Reported Spending for Medicaid Eligibility IT System Changes and Maintenance

The Centers for Medicare & Medicaid Services (CMS) expanded the availability of an enhanced federal financial participation (FFP) matching rate of 90 percent—which we refer to as 90/10 funding—to states' expenditures related to the design, development, and installation of new or improved Medicaid eligibility IT systems incurred from April 19, 2011, through December 31, 2015. States are also eligible to receive a 75 percent FFP indefinitely for costs associated with the maintenance and the operation of Medicaid eligibility systems that have been upgraded to meet applicable standards and conditions by December 31, 2015. States report these expenditures on the CMS-64—the form that states complete quarterly to obtain federal reimbursement for services provided or administrative costs incurred under the Medicaid program.[1] Table 3 summarizes total state reported spending on Medicaid eligibility IT system changes through the quarter ending September 30, 2014.[2]

[1]On the CMS-64, states report spending on in-house activities eligible for 90/10 funding on line 28A, and spending on contractors on line 28B, and in-house and contractor maintenance and operations activities on lines 28C and 28D, respectively.

[2]We reviewed states' reported expenditures for the quarter ending June 30, 2011, the first quarter for which 90/10 funds were available to states, through the quarter ending September 30, 2014. Three states (North Dakota, Oregon, and Washington) had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014

Table 3: Total State Reported Spending on Medicaid Eligibility System IT Changes and Maintenance as of September 30, 2014

State	In-state 90/10 spending	Contractor 90/10 spending	In-state 75/25 spending	Contractor 75/25 spending	Total reported spending
Alabama	$5,170,069	$1,341,257	$7,299,461	-	**$13,810,787**
Alaska	1,307,187	19,204,040	-	-	**20,511,227**
Arizona	9,957,785	41,748,707	5,797,994	34,768	**57,539,254**
Arkansas	3,998,136	53,727,254	1,662,815	-	**59,388,205**
California	1,755,810	2,828,851	-	-	**4,584,661**
Colorado	2,674,357	12,720,086	37,121	869,681	**16,301,245**
Connecticut	2,795,328	38,584,115	-	11,925,657	**53,305,100**
Delaware	1,022,010	40,264,574	-	-	**41,286,584**
Dist. of Col.	3,439,144	16,530,628	-	-	**19,969,772**
Florida	-7,879,873[a]	33,719,117	-	-	**25,839,244**
Georgia	210,375	7,502,091	-	-	**7,712,466**
Hawaii	950,532	79,261,121	-	4,737,774	**84,949,427**
Idaho	23,045,230	23,741,211	48,919	-	**46,835,360**
Illinois	5,987,078	52,896,697	-	1,443,257	**60,327,032**
Indiana	558,450	34,361,149	-	773,078	**35,692,677**
Iowa	8,956,964	22,052,952	2,617,445	2,011,912	**35,639,273**
Kansas	10,326,310	86,020,122	279,775	2,444,667	**99,070,874**
Kentucky	10,983,835	9,848,130	-	-	**20,831,965**
Louisiana	4,308,672	4,542,957	641,803	2,567,228	**12,060,660**
Maine	452,347	8,260,942	6,733,116	-	**15,446,405**
Maryland	22,043,672	12,169,926	210,922	4,871,496	**39,296,016**
Massachusetts	7,206,910	11,912,289	-	-	**19,119,199**
Michigan	24,168,007	8,564,219	-	-	**32,732,226**
Minnesota	48,777,337	-	-	-	**48,777,337**
Mississippi	68,664	4,722,020	-	-	**4,790,684**
Missouri	5,623,253	29,204,023	501,990	4,031,138	**39,360,404**
Montana	4,763,137	10,842,465	1,441,918	8,041,582	**25,089,102**
Nebraska	3,339,175	2,670,952	-	-	**6,010,127**
Nevada	2,782,492	7,693,947	172,398	643,580	**11,292,417**
New Hampshire	753,149	18,462,205	-	-	**19,215,354**
New Jersey	17,216,177	47,670,971	-	-	**64,887,148**
New Mexico	15,689,319	58,896,347	-	6,482,252	**81,067,918**
New York	843,341	25,413,361	-	-	**26,256,702**
North Carolina	45,723,278	134,970,026	715,579	1,190,671	**182,599,554**
North Dakota	6,906,772	-	-	-	**6,906,772**

State	In-state 90/10 spending	Contractor 90/10 spending	In-state 75/25 spending	Contractor 75/25 spending	Total reported spending
Ohio	1,541,835	47,755,188	18,070	36,407,474	**85,722,567**
Oklahoma	1,847,980	28,273,555	8,808	97,335	**30,227,678**
Oregon	21,232,087	30,938,470	-	-	**52,170,557**
Pennsylvania	3,401,484	102,938,028	-	1,818,209	**108,157,721**
Rhode Island	229,187	38,552,098	-	-	**38,781,285**
South Carolina	15,091,558	12,579,681	11,985	15,002,077	**42,685,301**
South Dakota	352,601	1,483,442	-	-	**1,836,043**
Tennessee	3,874,444	15,333,994	15,000,707	3,604,224	**37,813,369**
Texas	44,915,941	46,049,625	-	7,034,546	**98,000,112**
Utah	-	13,641,519	-	-	**13,641,519**
Vermont	2,461,339	11,841,813	-	-	**14,303,152**
Virgin Islands	-	465,549	-	-	**465,549**
Virginia	17,164,269	48,127,285	-	-	**65,291,554**
Washington	1,968,555	17,419,715	-	-	**19,388,270**
West Virginia	427,718	13,755,757	-1[a]	-	**14,183,474**
Wisconsin	16,290	20,851,548	117,094	43,285,828	**64,270,760**
Wyoming	269,553	9,650,226	-	2,562,187	**12,481,966**
National Totals	**$410,719,270**	**$1,422,006,245**	**$43,317,919**	**$161,880,621**	**$2,037,924,055**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-169.

Note: We reviewed states' reported expenditures for the quarter ending June 30, 2011, the first quarter for which 90/10 funds were available to states, through the quarter ending September 30, 2014. Three states (North Dakota, Oregon, and Washington) had not reported finalized spending data for the quarter ending June 30, 2014, and no states had reported any spending for the quarter ending September 30, 2014.

[a]Negative numbers represent prior period adjustments. States may adjust prior reported spending for up to 2 years after the expenditure was initially reported.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 1 2014

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICAID: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist*" (GAO 15-169).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID: FEDERAL FUNDS AID ELIGIBILITY IT SYSTEM CHANGES, BUT IMPLEMENTATION CHALLENGES PERSIST (GAO-15-169)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report.

Supporting the Medicaid enrollment process and aiding information technology (IT) changes in the states is an ongoing HHS priority. HHS worked very closely with all states over the past several years to ensure that the necessary systems would be in place to provide consumers with an effective and streamlined process for gaining access to health coverage in 2014. This work was coupled with significant federal support for the development of modernized systems to enroll people in coverage for which they are eligible. These efforts have been successful in enrolling eligible people in health coverage through the Marketplaces, the Children's Health Insurance Program (CHIP) and Medicaid. Since the initial Marketplace open enrollment period began, over 9.1 million additional individuals are enrolled in Medicaid and CHIP, approximately a 16 percent increase over the average monthly enrollment for July through September of 2013. The success of Medicaid and CHIP enrollment and the changes that federal funds allowed state IT programs to make contributed to the overall success of the Marketplace.

The Affordable Care Act changes presented a unique opportunity to develop new systems that were integrated with Medicaid claims systems and further the effective and efficient operation of the overall program. At the time, many state systems were antiquated, based on outdated technology with limited technical and function capacity to support the process. For example, 5 of the GAO's 6 reviewed states had IT systems dating 20-30 years, with North Carolina's system dating over 30 years and Hawaii over 25 years. Drastic changes were needed in state IT systems. Prior to 2011, costs for developing and maintaining Medicaid eligibility systems had been matched at a 50 percent rate, while costs for developing and maintaining claims processing systems are matched at a 90 percent and 75 percent rate respectively. Recognizing the challenge the status of state eligibility systems presented, and the need that such systems operate as an integral part of claims processing systems, HHS established the increased matching rate to support the development of more efficient and modernized eligibility and enrollment systems that would incorporate the new Affordable Care Act income standards (modified adjusted gross income, or MAGI), seamlessly coordinate with claims processing systems, and support the streamlined and highly automated consumer experience that was envisioned by the law. HHS did so by including eligibility and enrollment systems within the definition of the claims processing systems for purposes of making these upgrades. This change made available a 90 percent match for expenditures to modernize or replace aging eligibility and enrollment systems to meet the requirements of the Affordable Care Act (consistent with the 90 percent match rates available for the Medicaid Management Information System) and a 75 percent match rate to maintain these systems. While these enhanced match rates apply under the statute to Medicaid claims processing systems eligibility and enrollment systems were historically considered to be separate from claims processing systems. This was the first time HHS has applied the higher matching rate to eligibility and enrollment systems, recognizing that the required upgrades required for eligibility and enrollment systems would also integrally affect claims processing systems. As a condition for these higher rates, the regulations imposed standards and conditions in terms of timeliness, accuracy, efficiency, and integrity for mechanized claims processing and information retrieval systems in order to receive enhanced Federal Financial Participation.

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90/10 funding is an important federal investment to provide states the resources they need to make the systems improvements envisioned by the Affordable Care Act. These investments will lead to improved and streamlined systems that will also offset costs the federal government and states may incur as a result of out of date systems. Every state has taken advantage of these new funding opportunities and several states have made significant progress over the past three years. As the GAO report highlighted, 34 states used 90/10 funds to implement full system replacements of their eligibility systems and 17 states used funds to implement modifications. For example, Oklahoma and Colorado are processing eligibility decisions in real time, 23 states, including Georgia and Pennsylvania, have successfully implemented pre-populated online renewal forms, and state-based Marketplaces like New York and Kentucky are operating unified, seamless eligibility systems. All of these strategies are enhancing the consumer experience.

Recognizing compressed timeframes, HHS streamlined our review process to expedite states' access to funds and enhance review of state spending. HHS expedited Advanced Planning Documents (APD) Review, cutting review time from 60 to 30 days, provided enhanced review of the CMS-64, adding new lines to the CMS-64 and implemented a new financial management process in 2013 which allowed HHS to monitor funding for Medicaid eligibility IT system changes by the federal fiscal year which aligned states' approved APD budgets with expenditure data to ensure states did not exceed approved funding amounts.

The funding was part of a larger approach to support state systems and the Medicaid application process. HHS implemented a single streamlined model application for all insurance affordability programs that states could either use or adapt for their state, which supported the concept of "no wrong door" to apply to Medicaid. At the same time that HHS published the 90/10 regulation, we also worked in tandem with our colleagues at the Administration for Children and Families and the U.S. Department of Agriculture's Food and Nutrition Services to secure a temporary waiver of OMB's A-87 cost allocation requirements. This waiver allowed States that wished to build integrated systems to do so without having to allocate the costs of developing shared eligibility services to human services programs. The majority of states have requested and received approval for the A87 waivers. A three-year extension of the A87 waiver authority will enable states to complete their work on eligibility and enrollment systems integration through December 2018.

To further support system change, HHS used the Enterprise Life Cycle framework to review state progress, implementing templates and the Collaborative Application Lifecycle Tool repository to facilitate state's IT changes; this approach, overall, as GAO explained, created positive changes, with less costly and time consuming review and certification and allowing for improved project management.

In 2013, HHS issued new guidance and provided states with technical assistance through our State Operations and Technical Assistance (SOTA) teams, our Medicaid and CHIP Learning Collaboratives and other resources and tools. Amidst major programmatic changes during the course of 2013, HHS also took steps to engage states in their efforts to improve the efficiency of state Medicaid and CHIP program operations and our business processes with states with

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streamlined state plan amendment submissions and demonstration requests and enhanced data reporting and analysis capabilities, but also issued guidance and implemented new processes to promote enhanced accountability and oversight of federal-state spending.

HHS remains committed to supporting all states in implementing modernized eligibility and enrollment systems. We will continue to work with states to ensure full implementation of transferring applications in the Federally Facilitated Exchanges. HHS is committed to working with states to support and strengthen state Medicaid IT systems and appreciates the opportunity to discuss the recent and ongoing changes that have occurred.

Appendix III: GAO Contact and Staff Acknowledgments

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Staff Acknowledgements

In addition to the contact named above, Susan T. Anthony, Assistant Director; Carolyn Fitzgerald; Caroline Hale; Anne Hopewell; Drew Long; JoAnn Martinez-Shriver; Vikki Porter; and Hemi Tewarson made key contributions to this report.