

medicaid and the uninsured

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Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform

Executive Summary

The Patient Protection and Affordable Care Act, the health care reform legislation signed into law on March 23, 2010, expands Medicaid significantly to cover millions more low-income, uninsured individuals – primarily, working-age adults who have no previous experience in the program. Anticipating the possibility of an expanded national role for Medicaid, the Kaiser Commission on Medicaid and the Uninsured and Lake Research Partners recently interviewed Medicaid program directors, experts, and thought leaders concerning the opportunities for strengthening Medicaid's reach to consumers and motivating participation, as well as the related challenges. All of those interviewed saw in the prospect of a new “culture of coverage” and the expansion of Medicaid a strategic moment to recast Medicaid as an affordable health coverage program for working people and families, and to improve its enrollment and renewal operations. They viewed achieving strong Medicaid participation as essential to fulfilling reform's broader coverage goals. There was consensus on the following major points:

Medicaid's expanded coverage role under health reform and the mandate to obtain coverage call for introducing Medicaid to the public in a new way. Health reform's individual mandate to obtain coverage establishes an expectation that everyone should be insured, laying the foundation for a new culture of coverage in the U.S. The reform law designates Medicaid as the coverage pathway for low-income Americans, situating it firmly in the national coverage framework. For the expansion of Medicaid to millions more people to result in the hoped-for gains in coverage, the program needs to be introduced to the whole public and in ways that encourage the participation sought by the individual mandate. Steps to recast and strengthen Medicaid, improve outreach, and facilitate participation are essential to implement the mandate because most of the uninsured are low-income people whom Medicaid should now cover. The transformative changes that health reform brings about in Medicaid and system-wide present an ideal opportunity to give Medicaid an appealing new program name, such as *Healthy US*, that reflects a national identity, conveys that it (like private insurance) is health coverage for working individuals and families, and provides the foundation for effective outreach.

Making Medicaid enrollment and renewal easy is necessary to accomplish national coverage goals. Easy enrollment and renewal processes are fundamental to achieving robust participation in Medicaid. Although states have made great strides in this area for children, they have made less progress where adults are concerned. Widening Medicaid “on-ramps” by improving enrollment and renewal processes, using automation and technology to facilitate participation, developing more effective messages and outreach, offering diverse modes for enrolling, and partnering with community organizations, providers, and others would help ensure that Medicaid finds and covers eligible individuals and families. In many cases, a culture shift may be needed to reorient Medicaid management, systems, and caseworker training away from welfare-style “gatekeeping” and toward encouraging participation.

Federally led initiatives to develop model Medicaid systems and increased federal funding for state capacity-building are important. The infusion of millions more people into Medicaid creates a new impetus for automation and streamlining in state enrollment systems, especially in light of state workforce reductions and budget pressures stemming from the recession. Particularly given Medicaid's role in the overall coverage framework, it is appropriate for CMS to spearhead automation efforts by developing model enrollment systems for states and providing technical assistance and incentives to promote their adoption. States will need federal resources to build their capacity and to fund investments in systems, outreach, and other initiatives to strengthen Medicaid participation. Because there is wide variation across the states with respect to resources, capacity, and other variables, some states will need more federal help than others.

Medicaid coverage must translate into access to care. The success of efforts to improve participation in Medicaid depends in part on whether the program delivers what it promises – access to health care providers and services. Efforts to recast Medicaid could backfire if states try to market Medicaid to providers without better payment levels and other support – investments that are difficult for states to afford under current recessionary pressures – or if Medicaid enrollees cannot find doctors, dentists, specialists, or other providers to see them.

Medicaid can be promoted effectively. With an appealing name, underpinned by real, operational changes that make Medicaid consumer-friendly and improve support for providers, the program can be marketed effectively. The impact of messages that promote Medicaid as health coverage “pure and simple,” and that convey the value of the coverage and encourage enrollment, could be great. Affordability and high quality are also themes to highlight.

Health reform lays out a national plan for covering Americans that has a large expansion of Medicaid eligibility as its cornerstone. This expansion of Medicaid and the increased expectations of Medicaid to advance national coverage goals amount to a prescription to optimize enrollment in the program. That is, improving Medicaid's reach among eligible individuals and families is not merely desirable, it is essential to achieving health reform's central purpose. To fully harness the potential for Americans to view participation in Medicaid favorably, and to ensure that Medicaid programs are ready and able to take on their broadened role in 2014, tangible progress in these directions needs to begin now.

Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform

When President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010, he set in motion a major reform of our nation's health care system designed to achieve near-universal health coverage and make other important improvements. Integral to the new national coverage system outlined in the law is a dramatic expansion of the Medicaid program. Today, Medicaid covers nearly 60 million low-income people, including children and working-age adults, seniors, and people with disabilities. Beginning in 2014, Medicaid will be expanded to reach almost everyone up to 133% of the poverty level, and by 2019, the program is projected to cover an additional 16 million people – primarily, low-income adults previously excluded from Medicaid by federal statute and largely unfamiliar with it. Given the vastly expanded role of Medicaid under health reform and increased expectations of the program, the time for efforts aimed at maximizing participation in Medicaid is ripe.

Late in 2009, looking ahead to possible health reform legislation, including an individual mandate to obtain coverage and a major Medicaid expansion, the Kaiser Commission on Medicaid and the Uninsured and Lake Research Partners solicited perspectives and ideas from Medicaid program directors, experts and thought leaders to help assess the opportunities such developments might present for creating a fresh identity for Medicaid, enhancing its reach to consumers, and motivating participation. Of primary interest were views on what measures would be most effective in making Medicaid enrollment and renewal operate better for people. Those interviewed included state and federal Medicaid officials, policy experts on Medicaid and other low-income assistance programs, and representatives from the advocacy community. This report summarizes their feedback, which may help to inform the Medicaid policy and planning efforts involved in implementing the Medicaid expansion successfully at both the federal and state level.

Health care reform presents a timely opportunity to improve Medicaid's operation and reach

Although Medicaid today is a strong program, its reach could be greater and more effective. Medicaid could cover more of the eligible population if the program were presented to the public in positive new ways and, simultaneously, basic programmatic changes were implemented to make interacting with Medicaid a more positive experience. Work along these lines began in the late 1990s when efforts were first undertaken to de-link Medicaid from welfare. The purpose of further effort to de-link Medicaid from welfare is two-fold. First, it would eliminate vestiges of Medicaid's roots as a welfare program, including onerous eligibility procedures and a hostile bureaucratic culture that continue to stigmatize Medicaid participation. Second, it would help to correct persistent misperceptions about who Medicaid covers that prevent millions of uninsured individuals from realizing that they and/or their children can qualify for the program.

Health reform's expansion of Medicaid to cover adults as well as children with income below a federal threshold creates a strategic "moment" to strengthen Medicaid, and doing so is vital to accomplishing health reform's coverage goals. Since over half of the uninsured are low-income adults, reaching this population effectively is necessary to reduce the ranks of the uninsured

significantly. In that light, it “makes more sense than ever” to recast Medicaid as an affordable health coverage program for working individuals and families, and to anchor that re-messaging in real programmatic reforms. Experience from the recession shows that many parents seeking Medicaid or CHIP for their children – often, for the first time, due to loss of employment or declining income – found their way to the programs, and millions of otherwise uninsured children gained coverage as a result. With the broad expansion of Medicaid eligibility, initiatives to increase awareness of and interest in Medicaid are needed to help ensure that low-income uninsured adults, too, gain coverage through the program as intended.

Several important changes implied by health reform set the stage for improving Medicaid now.

New culture of coverage. The individual mandate to obtain coverage establishes an expectation that all Americans should be insured – a new “culture of coverage.” For the individual mandate to be accepted and supported by the public, individuals must be able to obtain coverage without undue burden, whether it is public or private coverage. Most uninsured Americans are low-income and many will qualify for Medicaid. Facilitating and promoting enrollment and renewal in Medicaid would align the manner in which the program is administered with the new pro-coverage norm.

Introducing Medicaid to the whole public. In the new national health coverage system, Medicaid becomes the coverage pathway for low-income people, including millions of low-income adults – both parents and adults without dependent children – who were excluded from Medicaid previously. Also, the health reform law establishes a uniform, national method for determining Medicaid eligibility in place of the varied methods states now use. This redefinition of Medicaid eligibility in national terms, in combination with the individual mandate, transforms the program in two fundamental ways. First, it situates Medicaid in the national framework for providing coverage. Second, it requires that Medicaid be introduced for the first time to millions of Americans. This pivot-point would be an ideal time to give Medicaid a new name, such as *Healthy US*, that would give the program a national identity, convey that it is health coverage for working individuals and families, and provide a platform for a fresh and appealing marketing campaign – to reach new program entrants, in particular. The choice by so many states to give their CHIP and Medicaid programs for children names that would appeal to families and sound like private-sector coverage (e.g., Healthy Kids, HUSKY, All Kids) offers support for this strategy.

Medicaid’s expanded role under health reform also points to needs for improvements in the program’s “on-ramps” and new Medicaid messages, information, and outreach approaches that promote participation. The infusion of millions more people into Medicaid creates a new impetus for automation and streamlining in state enrollment systems, especially given state workforce reductions due to furloughs and lay-offs and budget pressures severely sharpened exacerbated by the economic recession. Automation efforts might also gain momentum from “green” campaigns in some states.

Fitting Medicaid into the national coverage framework. Under the new system, each state must establish a website through which individuals can apply for Medicaid or CHIP as well as coverage offered in the state-based exchange. In this environment, differences in how Medicaid is presented compared with other health coverage will be apparent. It is essential that Medicaid be presented and seen as high-quality health coverage, and also that Medicaid’s advantages for low-income people relative to private insurance – its broader benefit package and strong protection against out-of-pocket costs – be highlighted.

People often mistakenly perceive Medicaid as a separate, government-run health care system and do not realize that although the program is publicly funded, enrollees get their care like other people, from private-sector providers and managed care plans. Sharpening outreach and information about Medicaid to communicate this more effectively could increase the program's appeal and strengthen public support for it. Also, given that many (especially low-income adults) may move back and forth between Medicaid and private insurance as employment and income fluctuate, smoothing coordination and transitions between Medicaid and private coverage will serve to solidify Medicaid's standing as a mainstream form of health insurance.

Backing up the enrollment card with access to care. The success of efforts to improve participation in Medicaid depends in part on whether the program delivers what it promises – access to health care providers and services. Efforts to recast Medicaid could backfire if states try to market Medicaid to providers without better pay and other support – investments that are difficult for states to afford under current recessionary pressures – or if Medicaid enrollees cannot find doctors, dentists, specialists, or other providers to see them.

Access to care in Medicaid is generally good, especially for children. In addition to office-based physicians, health centers are a major source of primary care access for Medicaid enrollees. In most states, most beneficiaries receive their care through managed care plans, which can often leverage stronger access by organizing provider networks. Still, low provider participation in Medicaid is a perennial problem, and gaps in access, particularly to dental care, adult primary care, and specialty care, are a significant concern. The health reform law takes major steps to improve access to primary care in Medicaid. The law requires states to pay 100% of Medicare rates for primary care services provided by primary care doctors in 2013 and 2014, in both fee-for-service and managed care; the payment increase is financed entirely with federal dollars. The new law also provides significant new federal funding for health centers, aimed largely at expanding their capacity to serve millions of new patients and to provide medical, oral, and behavioral health services in areas with shortages of medical personnel, where many low-income people reside.

Provider payment rates and administrative support are important levers for improving provider participation and access to care in Medicaid, but they cannot correct workforce supply and distribution problems that, though worse in Medicaid, are at the bottom of declining access system-wide. These problems require solutions that lie largely outside the Medicaid program. To help train and place more health care providers in low-income communities, the reform law includes important new investments in the National Health Service Corps and in a new program of health center-based residencies.

How Medicaid's reach to Americans can be strengthened

While health care reform and a large new pool of potential enrollees present an important opportunity to promote Medicaid, campaigns to market Medicaid and improve public perceptions of it will fall flat unless the systems through which people interact with Medicaid are streamlined and friendly. Thus, social marketing efforts must be underpinned by program operations designed to assure a positive applicant and enrollee experience. Some states are much further ahead than others in this respect, an unevenness that raises new issues in a system in which Medicaid now has a more national role.

Streamline enrollment and renewal. States have made substantial progress in simplifying enrollment, primarily for children. Indeed, nine states recently qualified for federal performance bonuses by adopting measures that facilitate participation and boosting children’s enrollment in Medicaid. Increasingly, states are taking advantage of technology to share data, enabling Medicaid agencies to obtain information they need to determine or renew Medicaid eligibility from other assistance programs with similar eligibility rules in which applicants or enrollees may already participate. Nearly half of all Medicaid programs are establishing citizenship now through a data match with the Social Security Agency, rather than requiring applicants to submit their original birth certificates or passports. Under the “Express Lane Eligibility” option for children, states can use eligibility findings from other programs as well as tax returns to identify children who are eligible for Medicaid and CHIP for outreach, and even to enroll them automatically rather than wait for the family to initiate the process. Electronic coordination of these kinds makes enrollment and renewal easier for individuals and families and improves participation and coverage stability.

Extend streamlining to adults, too. While states have made great strides in streamlining enrollment and renewal for children, the procedures for adults remain cumbersome in many states. Some states still require adults in families to enroll at Social Services offices. Some require frequent recertification, often causing lapses of coverage for bureaucratic reasons, disrupting enrollees’ care and undermining efforts to improve care coordination and management.

While health reform expands Medicaid eligibility to millions of adults, the likelihood that they will enroll hinges partly on the Medicaid enrollment process. Therefore, widening Medicaid’s “on-ramps” to make participation easy and coverage more stable is a first-order priority. Groups who are new to Medicaid may be especially sensitive to the enrollment process they encounter. In a recent study, families who became uninsured in the recession and had never applied for government programs before reported that they were put off from Medicaid by bureaucratic hurdles and sometimes demeaning treatment by caseworkers. Similar reactions might be expected from uninsured adults who will be interacting with Medicaid for the first time. Eliminating excessive requirements would make Medicaid participation simpler and dispel negative perceptions of the program that stem from such requirements. In short, making the streamlined processes that most states already use for children universal in Medicaid would support the individual mandate and the coverage goals embodied in health reform.

Health reform Medicaid changes boost simplification efforts. Three provisions of health reform go a long way to simplify Medicaid eligibility and boost efforts to streamline enrollment of adults. First, the new law largely eliminates the asset test that many states still apply when determining Medicaid eligibility for adults. Nearly all states have already dropped the asset test for children in Medicaid, recognizing that since low-income families rarely have substantial assets, an asset test serves only to impede participation and increase administrative burden. The federal elimination of the asset test sends a clear message that simplification is a goal of reform and paves the way operationally for achieving this result. Second, the reform law requires state Medicaid programs to use a new, uniform method for determining income eligibility for most individuals (modified adjusted gross income, or MAGI) in place of the varied methods they now use. Third, the reform law expands the state option to make presumptive eligibility determinations. These provisions simplify and reduce variation in eligibility determination and push toward streamlining the processes that people encounter when they seek Medicaid coverage. They also create the seamlessness in terms of eligibility that is

necessary to support smooth coordination and transitions between Medicaid and coverage offered in the exchanges.

CMS can drive automation and systems modernization. The infusion of millions more people into Medicaid creates a new impetus for automation and streamlining in state enrollment systems, especially given state workforce reductions and budget pressures stemming from the recession. Automation efforts might also gain momentum from “green” campaigns in some states. Particularly given Medicaid’s role in the overall coverage framework, it is appropriate for CMS to spearhead automation efforts by developing model systems for states and providing technical assistance and incentives to promote their adoption. Currently, states vary widely in the extent to which they have streamlined and automated their processes – a reflection of state priorities, political cultures, and budget pressures. With Medicaid in a new national role, this state variation has large funding and policy implications; substantial investments in automation should be considered as planning for implementation proceeds.

Maintain diverse enrollment options and partner with community-based organizations.

To maximize participation, it is essential to maintain multiple pathways for enrolling in Medicaid that accommodate the diverse needs and preferences of the eligible population. These pathways range from web-based processes to “one-stop” approaches housed in social services offices that facilitate participation in a broader array of assistance programs.

Mail, telephone, and internet options for enrolling in and renewing Medicaid are preferred by many people. When the state websites through which people can apply for public or exchange coverage become operational, these portals, too, will be an important mechanism for enrolling in Medicaid. Individuals who need application assistance or wish to enroll in other public benefits at the same time they enroll in Medicaid may prefer to enroll in person. Often, it is the most vulnerable people (e.g., the poorest, those with language or other barriers) who need the extra support that in-person enrollment processes can offer. Funding for enrollment assistance by the states can help ensure that, in particular, those facing the most barriers receive needed support in securing coverage.

Community-based organizations play a vital role as partners in outreach and enrollment assistance, particularly (but not only) with regard to populations with no previous experience with public programs. Many families affected by the economic recession have turned first to community-based organizations for help, and these organizations have frequently been instrumental in linking them with Medicaid and other assistance. The new outreach and enrollment challenges posed by health reform reinforce the importance of including community-based organizations in strategies to reach the eligible population. Low-income, uninsured adults without children, in particular, are a population largely unfamiliar with and unfamiliar to Medicaid, and every channel for reaching them will be needed. By making coverage nearly universal, health reform makes schools, health care providers, and employers natural outreach partners, as well; improved Medicaid payment may increase interest among primary care doctors in taking a more active role in enrolling patients in Medicaid. Equipping these and other settings adequately to provide information and act as enrollment outlets would increase the opportunities for eligible individuals, especially adults, to learn about and enroll in Medicaid.

Change the organizational culture. In many cases, it may be necessary to change the culture of the Medicaid bureaucracy, to orient the eligibility operation toward maximizing enrollment and retention, consistent with goals to increase coverage. In some states that have undertaken this kind of paradigm shift, caseworkers who once viewed themselves as Medicaid

gatekeepers now see themselves as agents for Medicaid applicants. Strong internal leadership is essential to champion and support changes in policies, procedures, systems, and training that align Medicaid eligibility operations with coverage priorities.

To implement the kinds of changes that are needed in state organizational cultures and operations will require adequate federal support. This support entails increased federal resources for state administration and staff to meet increased demands on and expectations of state Medicaid systems, as well as federal leadership – that is, Medicaid priorities, processes, and communications at the federal level that anchor and assist state efforts.

Promote Medicaid. The coverage goals of reform will not be achieved unless Medicaid succeeds in enrolling millions more low-income Americans. Easing the procedures for obtaining and keeping Medicaid would reorient the program toward these coverage goals operationally. As a complement to this operational streamlining, a marketing campaign that translated the new orientation into new outreach and messages – including, as suggested earlier, a new national program name or national “umbrella” name, such as *Healthy US* – could sharpen and improve Medicaid’s image among current and potential enrollees, further encouraging participation in the program. The thrust of such an initiative should be to promote Medicaid as health coverage “pure and simple,” to convey the value of the coverage, and to support enrollment. Affordability and high quality are also themes to highlight in messages. Inclusive outreach strategies that take into account the diverse composition of the Medicaid-eligible population are needed, as are strategies tailored to reach targeted subpopulations (e.g., Latinos, adults without children). Different messages may be resonant for different population subgroups.

Efforts to develop and ramp up improved Medicaid marketing and outreach need to start now so that when the Medicaid expansion takes effect in 2014, low-income Americans (as well as others) have a high level of awareness of the program and view participation in Medicaid favorably.

Conclusion

The health care reform law creates a national plan for near-universal health coverage that relies on a large expansion of Medicaid eligibility as its foundation. As the program directors, experts, and thought leaders interviewed for this project see it, this expansion of Medicaid and the increased expectations of the program to advance national coverage goals amount to a prescription to optimize Medicaid. That is, improving Medicaid’s reach among low-income Americans is not merely desirable, but essential to achieving health care reform’s objectives. Valuable guidance about what works and what is needed to optimize Medicaid can be found in the implementation successes demonstrated in CHIP and Medicaid with regard to children, and in the lessons learned recently from the experiences of families new to Medicaid since the recession.

With the public’s attention more focused on health coverage, there is a critical opportunity to convert the public engagement to increased coverage, through vigorous outreach and effective social marketing. As millions of low-income Americans gain eligibility for Medicaid for the first time and the individual mandate reinforces participation as a social norm, the conditions for promoting Medicaid are extremely favorable. Underpinned by easy enrollment and renewal processes, a pro-coverage organizational culture, and measures that strengthen provider participation, the impact of investments in a new program name or identity, strategic outreach,

and messages that convey the value of Medicaid coverage could be great.

Two major challenges need to be considered in shaping efforts to strengthen Medicaid's reach. First, the new national role that health reform assigns to Medicaid implies some revision of the federal-state relationship in Medicaid and raises questions about how to harmonize state discretion regarding Medicaid administration with national reform's Medicaid objectives. Because states' economies, budget circumstances, and political traditions differ, some states are further along than others in taking measures to ease and encourage participation in Medicaid, and some states are likely to resist moving in that direction altogether. How policymakers resolve whether to approach optimizing Medicaid enrollment as a federal or a state matter or something in between has significant implications for the effort's financing, its implementation, the state-federal partnership, and progress toward national coverage goals. In any case, some states will have further to go than others and will need more federal help.

Second, maximizing participation in Medicaid requires costly investments in improved systems and increased administrative capacity at the state level. Enthusiastic though support for strengthening Medicaid is, there is wide agreement that as states continue to struggle with recessionary pressures, they cannot afford the investments needed now to ensure that the systems and processes necessary to support reform are in place and ready for implementation in 2014. In light of state fiscal strains and, even more, given Medicaid's integral part in the national coverage strategy and HHS' central role in coordination and implementation, it is appropriate for the federal government to take the lead in developing model data and administrative systems for Medicaid and to provide technical assistance and incentives to states, such as enhanced federal matching funds, to encourage their adoption.

The horizon between today and full implementation of the Medicaid expansion and health reform overall is short. To ensure that Medicaid programs are ready and able to take on their broadened role in 2014, and to fully harness the potential for Americans to view participation in Medicaid positively, tangible steps that lay the foundation for this progress need to begin now.

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