Proven Strategies in Health Care Coverage Program Outreach and Enrollment

Final Report

November 29, 2012

Sean Orzol
Linda Barterian
Michael Barna

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Policy Research

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Mathematica Reference Number:
40090.003

Submitted to:
Missouri Hospital Association
Center for Education
4712 Country Club Drive, P.O. Box 60
Jefferson City, MO 65102-0060

Project Officer: Mary Becker

Submitted by:
Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-2583
Telephone: (734) 794-1120
Facsimile: (734) 794-0241

Project Director: Sean Orzol

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148 2010) provides an historic opportunity for states to significantly increase health insurance coverage among low-income populations, both by expanding eligibility to new populations and by moving to a more efficient, consumer-friendly application process. For the first time, Medicaid eligibility for the non-elderly population will no longer be based on age, disability, or dependents. The act establishes a new Medicaid eligibility category for non-elderly individuals, and extends Medicaid eligibility to all nondisabled, non-elderly citizens with income under 138 percent of the Federal Poverty Level (FPL), ($15,856 for an individuals or $26,951 for a family of three in 2013) (Missouri Department of Social Services, January 2013). In addition, premium subsidies will provide the opportunity for individuals from 138 to 400 percent of the Federal Poverty Level to purchase health insurance in the health insurance marketplace.

Along with these coverage expansions, the ACA contains numerous provisions that, together, are intended to move the Medicaid enrollment and renewal process from a complex, paper-based system to a streamlined, technology-supported and customer focused model. The ACA's Medicaid-related health reform provisions will dramatically change how state Medicaid agencies go about determining eligibility. Beginning in 2014, state Medicaid eligibility and enrollment systems are required to include the following:

- ***Standard, streamlined application for the insurance affordability programs***
- ***Applications accepted online, by phone, through the mail, or in person***
- ***A "no wrong door" enrollment procedure***
- ***Use of IRS modified adjusted gross income (MAGI) without an asset test to assess eligibility for most individuals***
- ***Electronic data matching to verify financial and nonfinancial information to the extent possible when determining eligibility***

Like many other states, once the expansion of Medicaid is implemented under the ACA, Missouri will face a number of challenges in enrolling eligible citizens. The newly eligible population in Missouri is not evenly distributed across the state, nor is it concentrated where current enrollees reside or where state caseworkers are located (Becker et al. 2012). Many of the newly eligible will have had no prior contact with public programs, particularly public insurance programs, nor recent contact with the health care system (Schwartz and Damico 2010b). Further, Missouri's current Medicaid eligibility and enrollment system must undergo sweeping changes to meet the eligibility determination and enrollment provisions required under the ACA. Developing an effective ACA Medicaid expansion strategy will require the state to build on its successes in other expansion efforts, and address these issues.

Recognizing the challenges Missouri faces, the Missouri Hospital Association awarded a contract to Mathematica Policy Research to conduct a study of outreach and enrollment best practices. This report presents findings from that study, which gathered insights from the literature and from interviews with key informants in Missouri and other states as well as national experts. It identifies key challenges Missouri will face in reaching and enrolling newly eligible individuals and summarizes what has worked best in other coverage expansions. Specifically, we examine

approaches for increasing awareness of program eligibility and program benefits, and effective strategies for enrolling large numbers of newly eligible people efficiently. We focus special attention on strategies likely to work best for the newly eligible population in Missouri. Our key findings are:

Mobilizing a broad network of local partners will be key to driving a comprehensive eligibility awareness and enrollment campaign.

Community partners, including nonprofit organizations, providers, and foundations, will play a critical role in making newly eligible individuals aware that they qualify for Medicaid or other coverage and motivating them to enroll. Community-based organizations (CBOs) provide a trusted voice to bring targeted messages to local populations, offer detailed program information, answer questions, and facilitate enrollment. Health care providers come into contact with uninsured individuals when they seek care and offer an appropriate setting for education about coverage options and enrollment assistance. Missouri has established strong partnerships with community organizations throughout the state. Collaborative relationships between multiple agencies, business leaders, foundations, and other local organizations developed through the state's Caring Communities and Community Partnership initiatives offer a valuable foundation to reach a diverse and newly eligible population. The Gateway to Better Health demonstration project illustrates the role of community health centers in reaching eligible adults through established relationships in their communities and facilitating enrollment. Both the Health Care Foundation of Greater Kansas City and the Missouri Foundation for Health have expressed interest in supporting the ongoing needs of community organizations to increase their capacity in support of a health insurance expansion. Missouri can further enable these partners by equipping them to play an active role in the application process.

Private sponsorship can supplement state and community-based eligibility awareness efforts to reach eligible individuals in new ways. Grocery stores, pharmacies, fast food restaurants, convenience stores, and large employers can be tapped to help advertise enrollment opportunities and distribute informational materials. Health plans played an important role in Missouri's CHIP outreach efforts, doing extensive marketing of the program through television and radio ads and billboards, and will likely be motivated to participate again.

New messages and new partners will be needed to effectively reach a diverse and newly eligible target population.

Use of new descriptive program names, promotional materials featuring representatives of target populations, multilingual marketing, and in-person contact with community-based partners can increase program awareness among diverse groups of eligible individuals. Messages should be simple and received multiple times from multiple sources by the target population. Hard-to-reach subgroups will require more targeted messaging delivered by trusted community-based organizations. Messages that resonate with low-income uninsured adults include describing coverage as "low-cost or free" (versus "affordable" or just "free"), highlighting the most valued covered services, which include hospitalizations, checkups, and prescriptions, and emphasizing the financial protection that health insurance offers.

Missouri has already begun to identify the uninsured population targeted under an expansion and has a variety of community partners willing to collaborate in a statewide eligibility awareness effort. Establishing new partnerships with CBOs that serve low-income adults and enabling them to assist with the application process would help reach this population. Recommended venues include unemployment offices, Supplemental Security Income (SSI) agencies, Supplemental Nutrition

Assistance Program (SNAP) offices, food banks, community college sites, job training programs, career centers, job fairs, housing assistance programs, churches, homeless or domestic abuse shelters, and literacy/GED programs.

A broad range of enrollment access points and customer-focused assistance is needed to promote enrollment and ensure vulnerable populations are enrolled.

Web-based application platforms will likely be the backbone of states' enrollment systems moving forward. Given the efficiency of these tools, states should promote their use as much as possible. Extension of web-based enrollment tools for mobile devices, including the development of software applications that allow users to apply and manage benefits using a smartphone, may offer a simple and efficient way for individuals to apply for coverage, particularly among young and minority populations. However, not all individuals will feel comfortable applying online, while many others will require help to do so or have questions about the program or their coverage options. Key informants stressed the importance of taking the application process to the target population. Several states have developed strategies to expand the number of locations where individuals can apply for coverage and receive assistance in filling out application forms, staffing them with individuals trained by the states in eligibility processes and available to assist with the completion of Medicaid and other social services applications.

A paperless eligibility determination process can streamline and simplify the enrollment and renewal process for both clients and staff.

Expanding Medicaid has the potential to almost double the number of individuals receiving public insurance in Missouri, a result that would likely overwhelm the agency's current capacity to process enrollments and renewals if new systems are not put in place. Missouri will need to look for ways to maximize the efficiency of its eligibility system to process enrollment and renewals. The message we heard from the vast majority of our key informants was that without dramatic simplification of eligibility determination at both enrollment and renewal, states are unlikely to be able to manage the demand placed on their eligibility systems. Other states have found that by basing eligibility determinations on data that is already available, they can make determinations quicker, reducing the burden on individuals and families seeking coverage, as well as the administrative burden on agencies. The state could also dramatically simplify the renewal process for individuals and decrease the workload for staff by adopting policies that promote continuous coverage, rather than disenrollment.

States should start developing a comprehensive approach to implementing expanded eligibility and modernizing their enrollment systems today.

In interviews with state and national experts, we consistently heard how important it is for states to develop a comprehensive approach to making the enrollment process work well and having that in place before individuals start enrolling. Training staff and community partners, building new relationships with stakeholders, redefining agency culture and goals, developing new messages, and implementing new policies are components of a comprehensive strategy that complement each other. Each piece is necessary but not sufficient for having a successful enrollment effort. State leaders can begin the process by developing a vision to expand health insurance coverage that fits state goals and priorities and enabling motivated partners and stakeholders to implement the policies, procedures, and actions needed to execute that vision.

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I. INTRODUCTION

Among the many reforms to the U.S. health care system detailed in the Patient Protection and Affordable Care Act (ACA) of 2010, one of the most significant is the expansion of Medicaid. For the first time, Medicaid eligibility for the non-elderly population (those under age 65) will no longer be based on age, disability, or dependents. The act establishes a new Medicaid eligibility category for non-elderly individuals and extends Medicaid eligibility to all nondisabled, non-elderly citizens with income under 138 percent of the federal poverty level (FPL), ($15,856 for an individual or $26,951 for a family of three in 2013) (Missouri Department of Social Services, January 2013).[1]

Medicaid and the Children's Health Insurance Program (CHIP) currently provide coverage to millions of individuals (10 percent of non-elderly individuals and 34 percent of children) but large gaps in coverage remain for many low-income adult populations (Kaiser Family Foundation [KFF] 2012c, 2012d). Prior to the passage of the ACA, Medicaid eligibility was limited to individuals who met financial eligibility criteria and also fell into specific categories, which were classified into five mandated groups (Schneider et al. 2002).[2] For adults without dependent children, there was no federal minimum eligibility level; states could only expand eligibility under a waiver of federal rules, known as a Section 1115 waiver, or by creating a state-funded program. Additionally, while all states cover some parents in their Medicaid programs, the federal minimum income thresholds are determined by states' July 1996 welfare eligibility level, which is below 50 percent of the FPL in a majority of states. This left millions of low-income parents ineligible for Medicaid coverage (Kaiser 2010), in large part due to gaps in public coverage eligibility. Adults at or below 138 percent FPL have a very high uninsured rate, with 44 percent lacking coverage in 2010 (Kaiser Commission on Medicaid and the Uninsured [Kaiser] 2012).

By moving to eligibility criteria based predominately on income, which the ACA does, historic gaps in Medicaid eligibility that occur as a result of family status are eliminated. The ACA will increase Medicaid eligibility for parents in all but 10 states and for adults without dependent children in all but two (Kaiser 2012; KFF 2012b). Were every state to expand Medicaid as outlined under the ACA, an estimated 12 to 13 million individuals will become newly eligible for Medicaid when the relevant ACA provisions take effect on January 1, 2014. The vast majority of these individuals are estimated to be adults (Buettgens et al. 2011; Harvey et al. 2012).[3]

In addition to the expansion, states will face additional challenges in meeting ACA provisions requiring states to design and operate coordinated, technology-supported Medicaid enrollment systems, regardless of whether states choose to expand Medicaid (Morrow and Paradise 2010; Musumeci 2012). Several ACA provisions will dramatically change how many state Medicaid agencies go about determining eligibility, the aim of which is to create an enrollment and renewal

[1] 133 percent of the FPL, with a 5 percent income disregard, makes the effective limit 138 percent (Camillo 2012).

[2] The groups for which Medicaid coverage is mandated are children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly.

[3] The Supreme Court ruling on the constitutionality of the ACA had important implications for Medicaid. The court ruled that states would not lose existing Medicaid funds if they did not expand Medicaid for all individuals under 138 percent of the federal poverty level, essentially making the expansion voluntary.

process that is simple, seamless and consumer friendly (Coughlin and Courtot 2012). These requirements include:

- ***Standard, streamlined application form*** for Medicaid, CHIP, and the Health Insurance Exchanges for individuals applying on the basis of income, creating a single entry for all three insurance affordability programs.
- ***Applications accepted online, by phone, through the mail, or in person*** to allow individuals the opportunity to choose how they apply for the program.
- ***A "no wrong door" enrollment procedure****,* requiring state Medicaid agencies to coordinate with other insurance affordability programs to enable seamless transition of eligibility information between programs.
- ***Use of IRS modified adjusted gross income (MAGI) without an asset test to assess eligibility*** for most individuals, increasing uniformity in income rules across states and programs (Camillo 2012).
- ***Electronic data matching to verify financial and nonfinancial information when determining eligibility.*** States will be require to establish, verify and update eligibility first by checking electronic data sources, such as a federal data hub established by HHS to get data from the IRS and other federal agencies, or other state databases, then asking for documentation if needed.

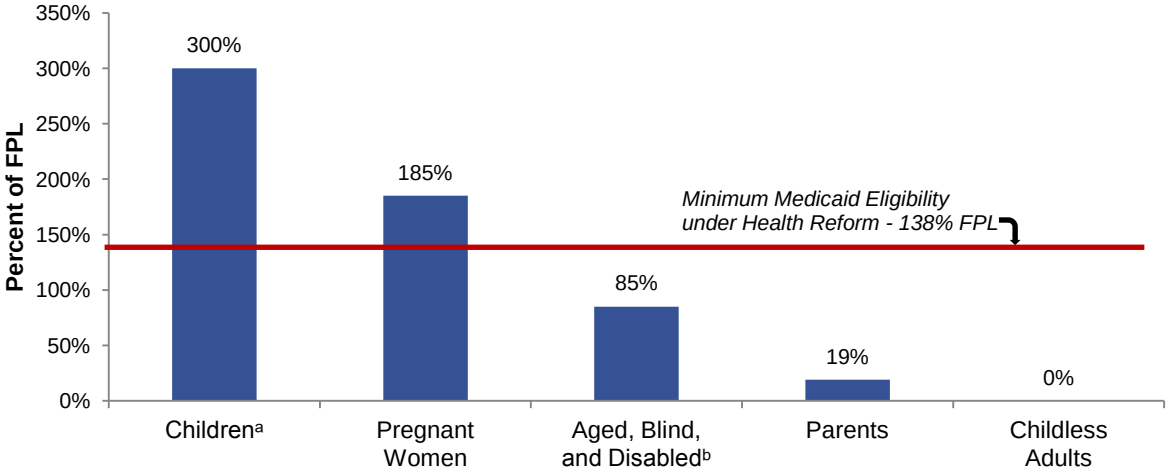
Taken together, the changes outlined in the ACA provide a historic opportunity for states to significantly increase health insurance coverage to their low-income populations, both by expanding eligibility to new populations and by moving to a more efficient, consumer-friendly application process. However, the effectiveness of the new model will ultimately depend on a state's ability to successfully implement these changes (Camillo 2012). The overall scope of the eligibility and enrollment changes mandated under the ACA will present enormous challenges for many states.

Challenges for Missouri

Missouri has generous eligibility criteria for children in its Medicaid (and M-CHIP) programs but Medicaid income thresholds for adults are more limited (Figure I.1). Missouri is one of 17 states with an income eligibility threshold for working parents at less than half of FPL; eligibility for custodial parents is at the federal minimum (19 percent of FPL). Working custodial parents can have a higher actual earned income but only if various income disregards reduce the countable income to 19 percent of FPL. For nondisabled adults nationwide, Medicaid coverage is essentially nonexistent. Like many states, Missouri does not offer a statewide Medicaid program with full benefits to this population[4]. Given this, the ACA Medicaid expansion is estimated to increase the number of Missourians eligible for Medicaid by 331,629 (U.S. Census Bureau 2012).

[4] Missouri operates a limited 1115 waiver program in the greater St. Louis area for uninsured adults (Gateway for Better Health).

Figure I.1. Medicaid Eligibility Limits in Missouri.



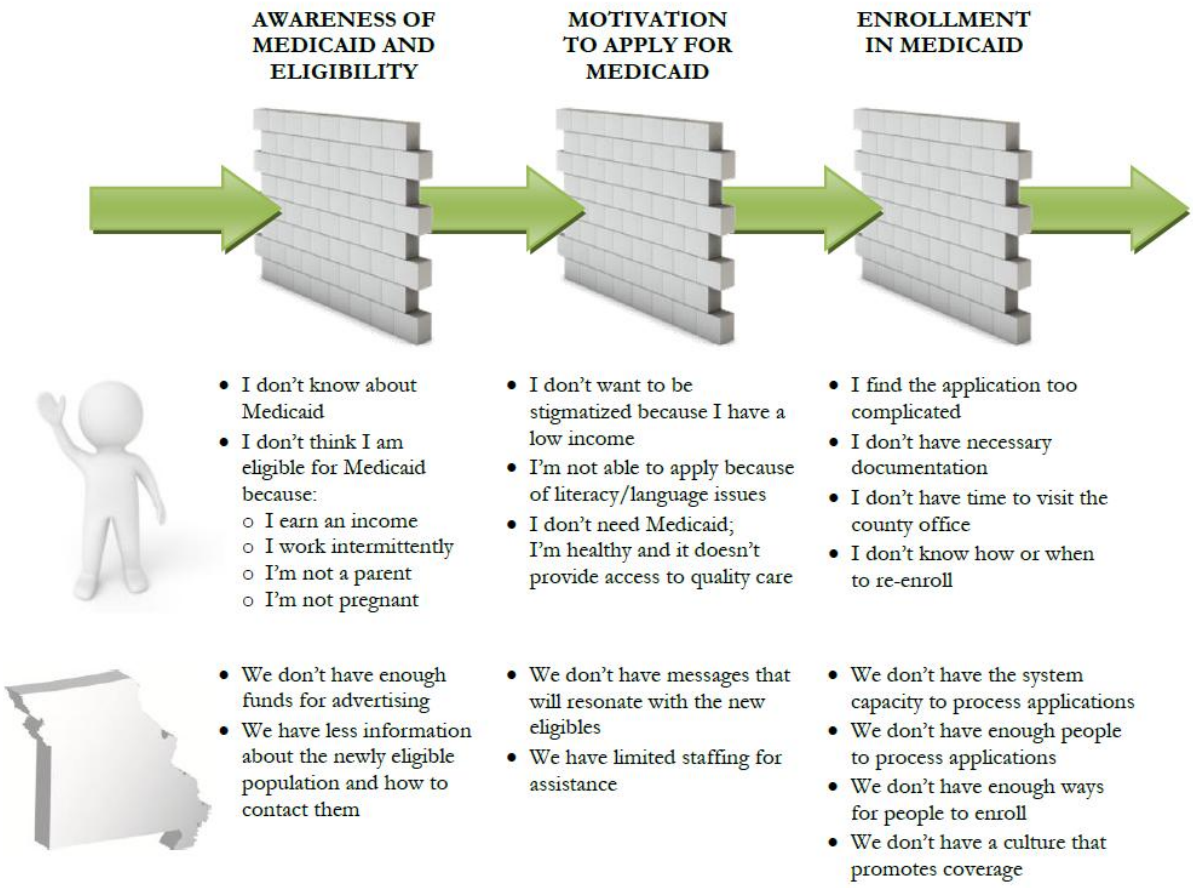
Source: Kaiser State Health Facts. Available at: http://statehealthfacts.org/index.jsp.

[a] The Medicaid eligibility limit for children ages 0–1, 1–5, and 6–19 is 185 percent, 133 percent, and 100 percent, respectively.

[b] An asset limit test of $1,000 for single persons and $2,000 for couples must also be met.

Like many states, Missouri will face a number of challenges in implementing the ACA Medicaid expansion once the state moves forward with the program. (Figure I.2). The newly uninsured low-income adults are a diverse group, varying in their age, family composition and health needs (Kenney et al. 2012; Schwartz and Damico 2010a). Many of the newly eligible will have had no prior contact with public programs, particularly public insurance programs, nor recent contact with the health care system (Schwartz and Damico 2010b). Many will lack awareness of new eligibility for Medicaid, particularly working individuals (Goldstein 2010; Ketchum and Lake Research Partners 2011; Lake Research Partners 2012). A perceived stigma of public assistance, limited appreciation for the value of health insurance, and concerns about poor treatment and a burdensome application process present additional barriers for newly eligible individuals (Goldstein 2010; Levinson and Rahardja 2004; Lipson et al. 2007; Stuber et al. 2000). For those who wish to enroll in Medicaid or other premium assistance plans, applying for coverage requires knowledge of how and where to apply, understanding application materials, and providing all required information. The application process can prove particularly difficult for individuals with limited English language proficiency, low reading levels, or mental/physical disabilities—challenges faced by a number of the newly eligible (Artiga et al. 2010; Lipson et al. 2007). The newly eligible population in Missouri is not evenly distributed across the state, nor is it concentrated where current enrollees reside or where state caseworkers are located (Becker et al. 2012). Further, Missouri's current Medicaid eligibility and enrollment system is antiquated and must undergo sweeping changes to meet the eligibility determination and enrollment provisions required under ACA.

Figure I.2. Barriers to Enrollment.



While strategies for reaching families with children may apply for some populations, different messages and approaches to outreach and application assistance will likely be needed for the majority of the newly eligible. Different strategies to identify new eligibles will be needed to ensure vulnerable or hard to reach populations are represented among the newly enrolled. Finally, additional processes and strategies will likely be needed to help the state manage the surge of expected applicants and prevent a backlog of cases from developing that would put timely coverage at risk for all eligibles, including children and pregnant women.

Contribution

To help Missouri prepare for the challenges in implementing the ACA Medicaid and premium assistance expansions and related changes to eligibility and enrollment systems, the Missouri Hospital Association asked Mathematica Policy Research (Mathematica) to conduct a study of outreach and enrollment best practices. This report presents findings from that study. It identifies key challenges Missouri will face in reaching and enrolling newly eligible individuals and summarizes what has worked best for other types of coverage expansions, such as the previous CHIP expansions, 1115 waiver expansions to similar populations, and the rollout of other government assistance programs, like the Medicare Part D prescription drug benefit. We examine approaches for increasing awareness of program eligibility and program benefits, and effective strategies for enrolling large numbers of newly eligible people efficiently. Specifically, this report addresses the following research questions:

- What outreach strategies have states and communities found work best to raise awareness of program eligibility? What messages are likely to work best with the adult populations targeted by ACA.
- What aspects of the Medicaid and premium assistance program are most appealing to individuals? What approaches have been shown to be less effective? Why do some people resist applying for coverage?
- What outreach strategies are effective in getting newly-eligible individuals to apply?
- What are the principle enrollment and renewal barriers states and communities have faced in enrolling large numbers of newly eligible individuals?
- What enrollment and renewal policies and practices are more effective in enrolling large numbers of new eligibles? Which strategies are most likely to be successful for the ACA Medicaid and premium assistance expansion population?

We focus special attention on strategies likely to work best for the newly eligible population in Missouri.

Study Approach

The study had a two-pronged data collection strategy. As a first step, we conducted a targeted literature review of published materials on the effectiveness of outreach and enrollment strategies. To supplement information gathered during the literature review, we conducted telephone interviews with a variety of key informants in Missouri and other states, as well as national organizations and foundations. (See Appendix Table A.1 for a list of informants.) In calls with informants in Missouri, we focused on their experiences with previous expansions—identifying strategies that have proved effective for finding and enrolling people in coverage, and also learning about how outreach and enrollment practices would need to be tailored for different populations and different geographic areas in the state. We spoke with informants from four states that expanded to populations similar to the ACA expansion population using section 1115 wavier authority or were identified as having taken successful steps in improving enrollment and retention in their Medicaid programs. We also interviewed informants from six national organizations and foundations that have been actively involved in promoting and studying state outreach and enrollment strategies.

Road Map for Report

The remainder of this report discusses our findings and recommendations. Chapter II describes Missouri's success in enrolling large numbers of uninsured individuals in previous insurance expansion initiatives. Chapter III outlines strategies designed to raise awareness of Medicaid and premium assistance program eligibility and the messages likely to resonate with newly eligible individuals. Chapter IV presents evidence on strategies designed to facilitate enrollment by providing assistance to potential enrollees. Chapter V presents findings on efforts to simplify the enrollment and retention process and Chapter VI summarizes and synthesizes findings from the study, and offers suggestions for Missouri in reaching and enrolling individuals under these expansions.

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II. MISSOURI'S EXPERIENCE ENROLLING POPULATIONS INTO HEALTH COVERAGE PROGRAMS

Expansion of Missouri's Medicaid program in 2014, as outlined under the ACA, would extend coverage to approximately 331,629 Missourians with incomes below 138 percent of FPL. Approximately 300,000 additional citizens will be eligible for premium assistance. These newly eligible populations include parents, childless adults, and disabled individuals. Many of these individuals reside in areas that are not well aligned with the state's current caseworker distribution. While Missouri will face significant challenges in identifying and enrolling this large and diverse population, the state has risen to similar challenges in the past, successfully enrolling large numbers of uninsured individuals in other expansion initiatives. Specifically, the state's success in enrolling children and parents in its CHIP program and current enrollment activities in support of the Gateway for Better Health program attests to its ability to forge effective public-private partnerships with stakeholders statewide who share a common goal of ensuring Missourians have health insurance coverage and can serve as models for future success with a Medicaid Expansion.

Missouri's CHIP Expansion

Missouri's CHIP expansion was viewed as an inspired success, both inside and outside the state (Cook et al. 2007). Implemented in 1998, Missouri expanded Medicaid eligibility by raising the income threshold for children to 300 percent of FPL—one of only five state CHIP programs to cover children from families with incomes at or above that level (Cook et al. 2007). Later, the state's Medicaid Section 1115 demonstration program extended eligibility to parents, substantially raising eligibility limits. This demonstrated Missouri's commitment to cover not only children but all family members (Harrington 2002). To facilitate Medicaid enrollment of eligible individuals, Missouri streamlined its process by eliminating a face-to-face interview requirement, simplifying the application to one page, and expanding the number of entry points by accepting applications through the mail and seven phone centers, which were added at the onset of the expansion.

Missouri used a grassroots approach to reach the newly eligible Medicaid population, providing support to 22 community partners throughout the state, enabling them to conduct local outreach and offer one-on-one assistance with the application process. State activities included producing and distributing program information materials; conducting more than 70 training sessions across the state for roughly 3,000 individuals who served as program "ambassadors" and spread the word to organization staff, clients, and others; training local department of health staff to perform enrollment tasks; and funding an outreach coordinator who traveled around the state to promote the goals of the program at schools, health fairs, local department of family services offices, and hospitals with outstationed eligibility workers (Harrington 2002). Allowing trusted local organizations to tailor eligibility awareness messages to the community they served proved an effective outreach strategy (Harrington 2002). The state also collaborated with state and local school lunch programs, school nurses in primary and secondary schools, Federally Qualified Health Centers (FQHCs), health departments, health plans, and the Missouri Hospital Association to reach eligible populations.

Missouri's expansion of eligibility under the CHIP program and its implementation strategy that combined local outreach with enrollment simplification coincided with a substantial increase in the number of children and parents receiving Medicaid coverage. Between July 1998 and March 2002, enrollment in the state's Medicaid program increased by more than 165,000 individuals, exceeding enrollment targets. Notably, while approximately 75,000 individuals enrolled under CHIP income

thresholds, an additional 90,000 new enrollees were eligible under the prior Medicaid income thresholds, suggesting that the state's outreach and enrollment simplification efforts had spillover benefits for families previously eligible for Medicaid (Harrington 2002). At its peak in March 2005, 546,000 children were enrolled in Missouri's Medicaid program, a 65 percent enrollment increase compared with the month before CHIP implementation (Cook et al. 2007). Coverage for parents also grew substantially in the years following this targeted eligibility expansion, with approximately 80,000 parents enrolling by 2001 (Harrington 2002).

Gateway to Better Health, Section 1115 Demonstration Project

In July 2012, a Section 1115 demonstration project in St. Louis County—Gateway to Better Health—began enrolling low-income, uninsured individuals not eligible for Medicaid into a health care coverage program. The project's goal is to maintain and enhance the region's health care safety net of primary and specialty care for uninsured and Medicaid populations until other coverage options become available January 1, 2014 under ACA (Centers for Medicare and Medicaid Services 2011). The program specifically targets young adults aging out of Medicaid and at risk of losing coverage, as well as individuals with chronic illness who may benefit from coverage.

The Gateway to Better Health project brought together providers, community-based organizations, and state agencies in a collaborative effort to identify, enroll, and deliver care to uninsured childless adults. The St. Louis Regional Health Commission (RHC), a not-for-profit, public-private partnership created to improve access to health care in St. Louis City and County, oversees the demonstration. The RHC and community health centers (CHCs) are spearheading outreach and enrollment activities, with support from the Missouri Family Support Division (FSD). The provider community is ideally qualified to lead the effort, building upon existing relationships with the target population, many of whom receive CHC services. Outreach to non-users of health services includes targeted mass media strategies, such as marketing on buses and billboards, letters, phone calls, events at health centers, and visits to local shelters, homes, and churches.

FSD partnered with the St. Louis RHC and three area clinics to implement the enrollment process for the Gateway program. FSD developed an application that is used to screen for Medicaid eligibility and then determine eligibility for coverage through the Gateway program. Applications are accepted at county FSD offices and FQHCs in the provider network. FSD also trained health center staff to provide on-site application assistance to work with individuals in completing their application forms and then forwarding them to an FSD enrollment site for determination of eligibility for coverage.

The Gateway program is an integrative health delivery model that has been recognized as a national model and adopted by other communities (Missouri Department of Social Services 2010). Missouri informants we interviewed cited the strong working relationships between providers, CHCs, RHC, and the state as integral to the success of the program. To date, more than 20,000 individuals have enrolled in the Gateway program. Lessons learned in reaching, enrolling, and delivering care to childless adults through collaboration in the state's most populated county can offer insights on implementation of effective statewide outreach and enrollment campaigns under a Medicaid expansion.

III. RAISING AWARENESS OF MEDICAID AND PROGRAM ELIGIBILITY

Improving public awareness of Medicaid and premium assistance program eligibility under the ACA expansions can help remove initial barriers facing newly eligible individuals. This is a first step toward achieving a significant reduction in the number of uninsured low-income adults. While many approaches that states have used effectively to increase awareness among populations targeted in prior public health insurance expansion efforts provide useful lessons, reaching uninsured low-income adults, especially those without dependent children, will require modifying these strategies and messages. Survey and focus group research offers insights about the perceptions and motivations of low-income uninsured adults. In addition, a number of states have already expanded Medicaid coverage to low-income childless adults through Section 1115 waivers and fully state-funded insurance programs. Although these programs vary in structure, financing, enrollment, benefits, and cost-sharing, the experience of these pre-ACA Medicaid expansion leaders provides valuable evidence of the challenges in reaching this population and approaches to overcome them (Artiga et al. 2010).

Aggressively promote Medicaid and premium assistance expansion using messages specifically targeted to raise awareness and change perceptions of Medicaid among newly eligible populations.

In various interviews, state and national Medicaid experts emphasize the importance of conveying the concept that "this is a new Medicaid program" and "the rules have changed" to broaden awareness of eligibility among low-income childless adults. Indiana's media campaign included the slogan, "We've got you covered" and an image of an umbrella to promote coverage to all uninsured adults (Artiga et al. 2010). Tennessee hired a public relations firm to create its slogan, "It's good for you, it's good for Tennessee," and targeted a broad population through billboards and radio and TV ads (Cohen and Wolfe 2001). Marketing materials that specify the actual dollar amounts that individuals and families can earn and still qualify for coverage can increase awareness among working families, especially those who do not think of themselves as "low income" and did not believe they were eligible (Lake Research Partners 2012).

In some cases, rebranding a state's Medicaid program can help combat perceived stigma and convey that the program now covers newly eligible adults as well as children and families. The term "childless adults" can cause confusion given that newly eligible adults will also include some non-custodial parents and parents with older children who are not dependents. Using a new program name can help clarify that all of these adults qualify for coverage (Goldstein 2010). For example, New Jersey announced the transition of its Medicaid and KidCare programs into NJ FamilyCare with a statewide multimedia campaign featuring parents, childless couples, single adults, and children—all eligible populations. Similarly, Pennsylvania's adultBasic clearly communicates that the program covers adults (Cohen and Wolfe 2001). However, experts caution that while rebranding can help signal change, it may also introduce confusion, especially to those currently enrolled. Further, it should only be used when real change is occurring and existing problems with the program are addressed.

Reaching low-income uninsured adults without dependent children will require new messages that resonate with this population and encourage them to apply for coverage.

Tailoring messages to target eligible populations has proven an effective strategy in prior public insurance expansions, increasing awareness and encouraging people to apply for coverage. Use of

new descriptive program names, promotional materials featuring representatives of target populations, multilingual marketing, and in-person contact with community-based partners have proven to increase program awareness among diverse groups of eligible individuals—groups often not reached by traditional media. (Children's Defense Fund 2006; Rosenbach et al. 2003; Wachino and Weiss 2009). In programs for children, for example, highlighting services that parents want for their children as well as the peace of mind that comes with health insurance coverage have helped demonstrate the value of program participation (Perry 2003).

According to a recent survey of low-income adults in Alabama, Maryland, and Michigan, a majority of this population views Medicaid as a good program and have a high interest in enrolling if they are eligible and uninsured (Lake Research Partners 2012). In describing Medicaid, participants identified several key points that can inform eligibility awareness messaging:

- "Low-cost or free" is preferred to "affordable" (a relative term) or "free" (this implies poor quality).
- Hospitalizations, checkups, and prescriptions are the most valued covered services. Highlighting these services and benefits of coverage may be more effective than messaging around prevention, particularly since many uninsured childless adults have been uninsured for a long time.
- "Staying healthy" and "protection from medical bills" are the two main motivations for having health insurance. Emphasizing the risks of being uninsured, including risk of injury or illness that may impact the ability to work and the financial protection that coverage provides, can be particularly compelling.

Experts interviewed for this report stressed the need to keep messages simple, deliver them repeatedly, and make program materials omnipresent to the target population. Many low-income, uninsured adults have never had health insurance. In addition, many read at a low level and have limited health literacy. Therefore, program information, application and enrollment materials, and correspondence from state Medicaid agencies should be clear and easy to read. One nonprofit leader noted, "The letters that come out for people to inform them if they are accepted or not are almost impossible for them to understand, and people don't know what to do next. We are big on health literacy, so we were pleased when we were asked to help simplify the letters under a grant-funded initiative to improve the enrollment process." Further, it is well proven that the number of times a message is received and processed by the target population strongly influences the overall effectiveness of eligibility awareness campaigns (Ringold et al. 2003).

A comprehensive eligibility awareness effort with an emphasis on community-based promotion will help reach a diverse newly eligible population and encourage them to apply for Medicaid and premium assistance coverage.

In previous public insurance expansion efforts, states used mass media campaigns to build broad program awareness along with community-based promotions to bring targeted messages to local populations. Combining these two strategies has proven effective in reaching target populations because the two approaches complement one another (Children's Defense Fund 2006). Many CHIP programs used broad mass media marketing to attract families' attention, build brand recognition, and spark interest in the program. They also used community based efforts and trusted local voices to contact families directly to discuss program details, answer questions, and assist with applications. While some states report large-scale marketing was less effective as public awareness of Medicaid and CHIP grew, it helped raise awareness and generated interest and excitement among

enrollees and community partners during the initial period after the expansion (Wooldridge et al. 2003).

Missouri's successful CHIP expansion effort was largely accomplished with minimal high-profile promotional efforts, which received less political and financial support than its grassroots, word-of-mouth approach (Harrington 2002). The state did engage in some targeted media campaigns in St. Louis and the Bootheel region, areas that had low enrollment levels. The campaign led to increased enrollment, supporting the view that media campaigns can be an effective complement to community based efforts. Interviews with leaders of Missouri community organizations revealed a general consensus that the low-profile approach made effective use of limited resources. However, while many leaders felt that large-scale media campaigns had limited effectiveness, several indicated that lack of a unified statewide campaign sometimes led to inconsistent messaging and gaps in outreach to hard-to-reach populations. They suggested that greater publicity, particularly using social media tools, could play an important role in a comprehensive strategy to reach the newly eligible population and deliver a consistent message.

Evidence on the value of a large-scale media campaign from states that have expanded coverage to childless adults is limited since many lack funding to support marketing activities (Artiga et al. 2010). Among expansion states that did conduct outreach, results remain mixed but may provide some support for a combination strategy. Wisconsin found that television, radio, and public service advertising was effective only early in the campaign, while enabling community partners to get the word out was more effective throughout the expansion. This was particularly true as they deployed regionally-based outreach through community-based organizations to get to hard to reach groups. In Massachusetts, dozens of corporate sponsors, including the Boston Red Sox baseball team, have supported the state's "Connect-to-Health" campaign and continue to participate in public education efforts. Labor unions, community health centers, hospitals, and advocacy and religious groups have joined the effort to promote coverage (Kingsdale 2009). While Massachusetts succeeded in dramatically reducing the number of uninsured in the state, it is difficult to discern the impact of its media campaign given that it was combined with extensive support of community-based outreach.

While evidence on the role of mass media campaigns is mixed, experts do agree that a comprehensive expansion effort will require a combination of strategies to target different segments of the uninsured population (Artiga et al. 2010). Mass media advertising can offer an effective strategy, particularly when target audiences are carefully selected. That said, literature from previous expansion efforts targeting families and children warns that mass media advertising requires frequent repetition to achieve desired objectives, perhaps a costly approach when resources are constrained (Children's Defense Fund 2006; Ringold et al. 2003). Finally, in addition to balancing mass media and local promotion campaigns, a toll-free hotline offers a valuable supplement to broader marketing efforts, providing a way for individuals to get further information and ask questions (Children's Defense Fund 2006).

Partnerships with community-based organizations who serve low-income adults without dependent children will provide customized ongoing messaging to help reach newly eligible individuals.

Experts agree that *who* delivers the message is of critical importance, emphasizing the role of trusted community partners in contacting hard-to-reach groups. Community-based organizations, such as schools, community health centers, and health plans, played a key role in broadening awareness in state Medicaid and CHIP expansions. Working with local organizations has also been shown to be an effective strategy to reach low-income beneficiaries eligible for the Medicare Part D

prescription drug benefit program (Laschober and Kim 2009). Community-based organizations offer a trusted source of information and can provide one-on-one assistance and long-term support to those they serve. Their relationships with the community prove particularly valuable in reaching diverse language, racial, and ethnic groups (Rosenbach et al. 2003; Wachino and Weiss 2009). Schools and adult education centers, health care provider facilities, community health centers, and social service agencies have served as valuable venues to distribute program information to target populations. Coordinating media and education efforts with local events hosted by community-based organizations at these sites has helped reach large numbers of potentially eligible families in a safe and trusted environment (Courtot et al. 2009).

Certain subgroups of the newly eligible populations will be difficult to reach, requiring more strategic efforts to overcome awareness barriers and provide motivation for individuals to apply for coverage. Some minority communities may have a high distrust of government and respond more positively to messages coming from church or other community leaders whom they trust. State and national experts we spoke to indicate that rural residents may have conflicting views about the program—a deep distrust of government but a high interest in obtaining coverage. Both the literature and experts recognize the value of involving community members in designing eligibility awareness initiatives. Their input can help guide message content and assist with appropriate translation for non-English speakers to facilitate connection with population subgroups. (Children's Defense Fund 2006). Enlisting the help of representatives from the target population who have already enrolled and benefited from these programs to deliver program information can also be a particularly effective approach to reach specific hard-to-reach populations in a personalized way.

Missouri relied on a grassroots, word-of mouth approach to drive the state's outreach campaign for its initial CHIP expansion, with most promotion of the program taking place at the local level, while state efforts focused on providing tools to support these activities. As a way to effectively engage local groups, Missouri established strong working relationships with 22 community partners throughout the state to promote the CHIP program. Using a public-private collaborative approach, these partners engaged community leaders in eligibility awareness efforts and tailored delivery of information to local target populations while the state provided needed training, and technical assistance. Consumer input solicited through polling and focus groups helped shape effective messaging to reach newly eligible groups. The state continues to build upon investments and previous successes through the Family and Community Trust (FACT), a nonprofit corporation providing leadership for Missouri's Caring Communities and Community Partnership initiatives. FACT brings together leaders of multiple state agencies, business leaders, local citizens, foundations and other community organizations to address challenges and offer an effective model for an integrated approach to reach a diverse and newly eligible Medicaid expansion population.

Some states have enlisted the support of managed care plans in previous Medicaid expansion efforts (Wooldridge et al. 2003). Several experts indicated that working with health plans offers a valuable component to a comprehensive strategy to increase awareness of eligibility, although their geographic reach in Missouri might be limited. While partnering with health plans can raise concerns about how to prevent marketing abuses, many states, including Missouri, successfully partnered with health plans to assist in CHIP outreach efforts. Some health plans participating in this effort sponsored extensive television and radio ads, billboards, and widespread distribution of program materials. Health plan participation allowed promotion of the CHIP program within limits: all marketing materials had to be approved prior to use, marketing messages had to clarify the program as distinct from the choice of health plan, and contact with potential enrollees prohibited discussion of choice of plans or implication that the plan is the only choice available under Medicaid (Harrington 2002; Wooldridge et al. 2003).

Since many childless adults have little contact with public assistance programs, reaching them through organizations and settings they frequent may require states to pursue nontraditional community partnerships. Interviews with state and national experts suggest a variety of options to reach low-income childless adults in locations they frequent, which may offer new partnership opportunities. Recommended venues reflect the mix of characteristics of the population—low-income employed, unemployed, young adults, and minority groups—and the financial pressures they often face. Unemployment offices, Supplemental Security Income (SSI) agencies, child support enforcement agencies and SNAP offices were seen as key opportunities to reach potentially eligible adults seeking non-health care related assistance. Unemployed, under-employed, or seasonally employed workers may be reached through job training programs, career centers, job fairs, or programs serving migrants and other seasonal workers. Other potential avenues mentioned include community college sites, housing assistance programs, food banks, churches, homeless or domestic abuse shelters, and literacy/GED programs. Establishing partnerships with local employers who do not offer health insurance to their employees is another way to reach individuals who may qualify for Medicaid (Harrington 2002). One national expert suggested working with employers to provide information at employee orientations and potentially build relationships with industries and employers that may face future layoffs in order to identify newly eligible individuals. Missouri's working relationship with its community partners offers a stepping stone to many community groups and organizations.

States that have implemented coverage expansions to uninsured childless adults through Section 1115 waivers and state-funded plans have relied heavily on community partners to help increase eligibility awareness. Examples of these state efforts include:

- ***Wisconsin:*** The Wisconsin Department of Human Services helped train approximately 3,000 people and representatives from 200 organizations to assist in outreach activities. Bilingual, culturally-sensitive marketing materials were distributed through county agencies. Collaboration among community partners created greater awareness and, according to one expert, "generated a level of buzz that is unprecedented." In a qualitative review of a program, interviewees suggested that the bilingual and culturally-specific promotional materials assisted in the enrollment of certain target populations (Hynes and Oliver 2010).
- ***Colorado's*** pre-ACA Medicaid expansion to low-income adults without dependent children offers several valuable lessons. A broad group of stakeholders worked to design a plan that would extend coverage to 10,000 adults with incomes at 10 percent of the FPL or lower. This enrollment limit allowed Colorado to provide coverage to an anticipated high-needs population without overwhelming existing enrollment capacity or exceeding the program budget. The income limit targeted primarily homeless men, and Colorado's targeted outreach approach enlisting community-based organizations, advocacy groups, and providers serving this population to assist county Medicaid offices proved effective in reaching this particularly hard-to-reach group. Based on the success of this initial small-scale expansion, the state is now considering approaches to expand further—once again, in a carefully measured way, incorporating stakeholder input and engaging community partners.
- ***Vermont*** focused some of its outreach efforts at state colleges, finding success in reaching the healthy young adult population by targeting parents and graduating students and providing information about health care coverage (Artiga et al 2010).

Health Care Providers

State and national experts strongly agree that providers have a key role to play in reaching uninsured adults who may be eligible for Medicaid or premium assistance, and empirical evidence lends some support to this view. Providers have contact with uninsured individuals when they seek care, often at community health centers, emergency rooms (ERs), drug treatment programs, behavioral health clinics, and health fairs. Studies have found that low-income adults view insurance as a serious issue and believe health care facilities, including doctors' offices, clinics, and ERs, are appropriate settings for education about coverage options and enrollment assistance (Cohen and Wolfe 2001; Lake Research Partners 2012). Further, providers have a financial incentive to support eligibility awareness efforts and facilitate coverage in order to receive reimbursement for the services they provide.

States that have expanded Medicaid coverage to low-income adults have worked to build relationships with providers to support program awareness efforts. In Missouri, the "Gateway to Better Health" section 1115 demonstration project to enroll low-income, uninsured individuals not currently eligible for Medicaid into a health care coverage model, enlists community health centers to increase awareness in their neighborhoods through letter, phone calls, events at health centers, and visits to shelters, homes, and churches. Community health centers offered a trusted source to deliver targeted messages and counter any conflict between distrust of government and the desire for health care coverage encountered among the eligible population. In Wisconsin's waiver-based expansion, HMOs enlisted advocacy groups to conduct outreach to uninsured adults, which was instrumental in getting the word out. Vermont found the strategy of providing health program informational materials with prescriptions at pharmacies, in community health centers, and clinics more useful than traditional outreach at health fairs and other community events. Oregon also distributes program materials through hospitals, family planning clinics, Federally Qualified Health Centers, and drug and alcohol centers (Cohen and Wolfe 2001).

Public-Private Partnerships

In addition to health care providers, states have partnered with businesses to advertise programs and distribute informational materials. For example, New Jersey teamed up with grocery stores, pharmacies, Kmart, Walmart, and McDonald's to distribute program flyers in their stores (Cohen and Wolfe 2001). Similarly, Colorado worked with 7-Eleven to conduct outreach in the company's convenience stores (Courtot and Coughlin 2012). In Massachusetts, a coalition of hospitals, employers, and insurers launched a media campaign to boost public support for its program. One expert identified the importance of engaging employers to help reduce the number of uninsured, "If we want a growing dynamic state, we need not only an educated workforce but a healthy workforce."

Training and Support for Community Partners

The literature and interviews with state experts highlight the importance of conducting individualized training sessions and providing ongoing support for community-based outreach partners. Training efforts have focused on building staff knowledge of program eligibility as well ensuring accuracy of messaging. Some states have implemented reporting requirements for community partners to help evaluate impact, made quarterly site visits to participating organizations to address obstacles and answer questions, and convened statewide or regional conferences to provide training as well as opportunities for partners to collaborate and share approaches for reaching target populations (Courtot and Coughlin 2012).

Use of third-party data may help identify eligible individuals.

States can use third party data to identify individuals eligible but not enrolled in Medicaid and use mailings or other outreach messages to inform them of the program. (Edwards 2009). For instance, some states are using adjusted gross income and other information on state tax returns to identify individuals who appear eligible for their Medicaid programs. Iowa, Maryland, and New Jersey have placed questions on their state income tax forms to identify families with uninsured children and then follow-up with a letter explaining the child's potential eligibility in Medicaid and an application form. Tax returns have the potential to reach a large number of the uninsured, an estimated 89 percent of uninsured children who qualify for public coverage live in families that file tax returns (Dorn 2009). However, the effectiveness of such programs remains in question. First year results of the Iowa's hawk-I outreach project were tepid: of the 57,450 hawk-I brochures sent, 475 were returned, resulting in only 471 previously uninsured children obtaining coverage (Freshour-Johnson 2010).

Social media can offer a new tool to include in a comprehensive eligibility awareness plan.

Many state and national experts point out the value of using social media to reach low-income childless adults. Social networking tools such as Facebook, Twitter, YouTube, and MySpace, may offer a cost-effective and timely way to customize messages for a variety of audiences. These messages can be easily tested, evaluated, and adjusted to address changing needs. While there may be population groups that lack Internet access or are reluctant to use online tools, one focus group study showed that email access and usage are high among childless adults. Further, the study found that the childless adult target population is receptive to receiving text or email program correspondence (Goldstein 2010). Several experts also believe that mobile phone use in the low-income adult population is relatively high. Further, social media tools can help states communicate with community partners, responding to feedback and facilitating idea sharing.

Several states and government agencies have already implemented social media-based strategies. Through its State Health Access Program (SHAP) grant, Oregon developed a social marketing campaign to advertise children's coverage programs using Facebook, MySpace, Twitter, YouTube and other social tools to make resources accessible to outreach partners and consumers. This approach allowed the state to test different messages to determine which ones were most effective in reaching the target population (Courtot and Coughlin 2012). The Centers for Disease Control has created a social media toolkit for teen pregnancy prevention and a variety of resources including guidelines and best practices for planning social media activities (www.cdc.gov/socialmedia). Other examples and resources for designing a social media campaign are available at the federal government's AIDS website (http://www.aids.gov/using-new-media/getting-started).

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IV. FACILITATING ENROLLMENT THROUGH APPLICATION ASSISTANCE

As new populations become eligible for subsidized coverage for the first time, including many who have never had insurance in their adult life, states will need to ensure that well-trained individuals are available to explain eligibility guidelines and options (Sullivan 2012). Applying for coverage requires knowledge of who is eligible to apply, the application process and materials, and the ability to answer questions. Some newly eligible adults may face significant challenges that impair their ability to complete the application process. Many low-income childless adults have limited English proficiency and low literacy, which makes it difficult to understand and complete an application. Individuals with mental health conditions, substance abuse problems, or physical disabilities may be unable to complete the enrollment process without assistance (Artiga et al. 2010; Lipson 2007)

Additionally, as states move toward online and other technologically driven application processes required under the ACA, they will need to be mindful that some subgroups—older, low-income, rural and non-English speaking—may have barriers preventing them from accessing or navigating through enrollment. States will need to be prepared to provide assistance and convenient alternative application methods. Many individuals will still want and need person-to-person contacts to help with the application process. The literature and interviews with national experts stress that some groups—low-income, rural, and non-English speaking individuals—are particularly less likely to complete an online enrollment process than other enrollees (Brooks and Kendall 2012; Leininger et al. 2011; Lake Research Partners 2012). Because many newly eligible individuals will be in working families, offering assistance during non-work hours in alternative setting will be especially important.

Community-based outreach workers, "outstationed" eligibility staff, providers, and private companies can all play an important role by helping individuals and families understand and complete the application process. Several states have developed strategies to expand the number of locations where individuals can apply for coverage and receive assistance in filling out application forms, staffing these locations with individuals trained by the state in eligibility processes and are available to assist with the completion of Medicaid and other social services applications. Locations can include local health departments, faith-based organizations, hospitals, and schools, staffed or unstaffed self-service kiosks located in high traffic areas, as well as phone assistance centers.

Lessons from Coverage Programs for Children

Application assistance programs were a critical part of the CHIP program's initial outreach and enrollment strategy. Community-based outreach is often judged as the only way to identify hard-to-reach families such as ethnic minorities, Hispanic families, and working families that had no prior experience with public programs (Hill et al. 2004). To facilitate this effort, community groups certified as "application assistors" are provided training in CHIP and Medicaid eligibility rules and procedures and/or received funding from many states. Other states developed alternatives to this approach. Rather than funding community organizations, Missouri established regional "phone centers" to provide a similar type of application assistance by Medicaid eligibility staff. These individuals were specially trained to answer questions and could take applications over the phone. The congressionally-mandated evaluation of CHIP found that, "while application assistance efforts have faced various challenges in implementation, they were almost universally praised as an effective strategy for taking outreach beyond an activity that simply informs families of the availability of coverage, to one that produces tangible, measurable results (in the form of enrolled children)" (Hill et al. 2004).

The available evidence suggests that offering in-person eligibility assistance can boost enrollment in public insurance programs, particularly among hard-to-reach populations such as non-English speakers, those with immigration concerns, and individuals with little experience with the social service system. One widely-cited study examined the impact of community-based application assistance programs in California and found that application assistance increased Medicaid enrollment, particularly for Hispanic (4.6 percent) and Asian (6 percent) children (Aizer 2003). Another study examined the effects of different types of application assisters in California, finding that nontraditional outreach partners, such as insurance brokers, played an important part in the enrollment of children by providing an entry point for higher income individuals, many of whom likely had little contact with more traditional outreach partners (Jacobson and Buchmueller 2007).

A study of a community-based case management outreach program in Boston targeted to Hispanic children found that uninsured children assigned to a community-based case manager were substantially more likely to obtain health insurance (96 percent vs. 57 percent) than children who received traditional outreach and enrollment services (Flores et al. 2005). Wolfe and Scrivner (2005) examined the effect of facilitated enrollment activities on insurance coverage using two years of data from the Current Population Survey. The study finds that application assistance strategies, such as a family-friendly websites and dedicated telephone centers have a positive effect on children's take-up of public coverage.

State Experiences with Adult Populations

Several states have developed assistance programs to complement application simplification efforts using technology.

- **"Gateway to Better Health," Missouri's** section 1115 demonstration project providing financial support to health centers in the St. Louis area, has implemented a pilot program to enroll low-income uninsured individuals who are not eligible for Medicaid into a coverage program (Centers for Medicare and Medicaid Services 2011). The Missouri Family Support Division (FSD) has partnered with the St. Louis Regional Health Commission and three area clinics to implement the enrollment process for the coverage program. The FSD developed an application for the program that is used to screen for Medicaid eligibility and determine eligibility for the coverage program. The FSD has also trained key health center staff to provide application assistance. These individuals work with individuals to complete the program application, then forward the applications to an FSD enrollment site where staff conduct eligibility determination for the Gateway program. The project has gathered providers, community-based groups, and state agency staff in a broad-based effort to identify, enroll, and deliver care to childless adults.

- **Massachusetts** awarded $11.5 million in grants to a broad network of community partners, including community health centers, hospitals, and non-profit organizations, to provide education and application assistance for its MassHealth program. These partners are able to apply for coverage online on behalf of an individual through a "Virtual Gateway" system that determines eligibility for MassHealth (Guyer et al. 2012). These partners help individuals gather necessary paperwork, and track the outcome of enrollment status over time. Because provider payment is tied to a successfully completed application form, safety net staff frequently follow-up with applicants to ensure all requirements are met. The virtual gateway program has been widely regarded as successful for facilitating enrollment and creating administrative efficiencies:

  - Six of every 10 families that have enrolled in public coverage have done so with the assistance of a community-based partner or provider (KFF 2012a).
  - For applications entering through the virtual gateway, safety net providers and CBO's shouldered much of the interviewing and data entry, tasks traditionally handled by social services staff (Dorn et al. 2009).
  - Applications had fewer errors and were processed more rapidly and less expensively than traditional applications (Dorn et al. 2009).

- **Wisconsin** similarly expanded enrollment locations beyond county offices to coincide with the implementation of its BadgerCare Plus program in 2009. Wisconsin developed partnerships with more than 200 community organizations— community health centers, hospitals, food pantries, schools and faith-based organizations—to identify and enroll individuals (Commonwealth Fund 2009). These partners were trained to use an online application system (ACCESS) to help individuals with the process. Wisconsin also awarded "mini-grants" of up to $25,000 to community-based organizations to share information about the program's benefits and provide direct, confidential application assistance to families (Hynes and Oliver 2010).

- **New Mexico** has installed standalone enrollment kiosks at community centers and schools to allow individuals to apply for public insurance online, eliminating the need to visit enrollment offices (Carroll et al. 2010). The state plans to staff the kiosks with trained application assisters to help with the application, scanning of documents, and entering electronic signatures. The majority of these kiosks will be located on reservations in order to reach those living in rural areas, where enrollments offices may be prohibitively far away. However, **Alabama** has had mixed results using kiosks in malls and similar public places, finding that people were not comfortable using them because others could see them applying for public benefits.

Several states use telephone call centers to provide assistance and facilitate enrollment and renewal:

- **Missouri** established and supported seven regional telephone assistance centers as a way to promote, streamline, and facilitate enrollment early on after the state implemented its CHIP program. The centers, which many believe contributed to the state's enrollment success, served as a resource to answer questions and help callers obtain and complete Medicaid applications (Harrington 2002). Phone center staff, specially trained to support enrollment into the Medicaid program, were able to take an applicant's personal information, make a preliminary eligibility determination, and then mail the application to the parent for a signature. The phone centers provided additional points of information and entry to those unable or unwilling to visit the FSD. They also created some distance and a certain amount of anonymity for people who do not want to be seen accepting government assistance (Harrington 2002).

- Like Missouri, eligibility and enrollment in **Louisiana** is conducted by Medicaid analysts at local (28 regional) offices. To help assist non-English speaking clients with the application process, Louisiana created a centralized, phone-based strategic enrollment unit, which handles eligibility/enrollment and renewal processes for Spanish- and Vietnamese-speaking families (with other languages contracted out) (Adams et al. forthcoming).

- **New York** has established a consolidated call center for its public health insurance programs. This center is designed to supplement the existing enrollment infrastructure and provide beneficiaries with a centralized, statewide system for processing renewals, providing enrollees and prospective enrollees with program information, assisting with applications, and resolving enrollee complaints. The call center offers integrated voice recognition capabilities, allowing for 24 hour a day service, as well as providing assistance for non-English speakers (State of New York Department of Health 2010).

V. ENROLLMENT AND RETENTION SIMPLIFICATION POLICIES

Medicaid and other public assistance programs can struggle to maximize coverage if application and renewal processes are complicated and time-consuming (Hoag et al. 2011). A complex enrollment process, especially when anticipating a surge in enrollment, can deter would-be enrollees from applying and put additional stress on limited state resources. Current state systems will be unable to efficiently absorb the millions of individuals made newly eligible under the Medicaid and premium assistance expansions, creating an incentive for states to expedite the transformation of their eligibility systems. The core principles that should drive Missouri's efforts to simplify its administrative processes are an interest in reducing the complexity of the process, decreasing the number of steps individuals and staff need to complete enrollment, and making the system more consumer friendly (Wachino and Weiss 2009).

Simplifying the process for individuals to apply for coverage is considered a vital step toward increasing enrollment in Medicaid, as well as minimizing administrative burdens on program staff. Since the start of the CHIP program, states have undertaken various strategies designed to streamline and reduce steps to get people enrolled in the program as well as Medicaid. Studies of these enrollment simplification policies find that presumptive eligibility, self-declaration of income, joint applications, and the elimination of asset tests generally increase take-up of public coverage (Bansak and Raphael 2007; Kronebusch and Elbel 2004; Wolfe and Scrivner 2005). Applicants benefit from a simplified procedure by being able to submit their applications more conveniently and easily, and program administrators benefit by having applications that are less complicated to process.

Furthermore, simplifying the renewal process has become a central strategy of states to gain administrative efficiencies and improve retention (Brooks and Kendall 2012). Most enrollment losses occur at the time of renewal, and a large portion of those are due to administrative issues rather than ineligibility or transitions to private coverage (Summer and Mann 2006). This can lead to unnecessary churning, where people eligible for Medicaid disenroll from the program only to reenroll a short time later, which can be administratively burdensome and costly. For example, between 2002 and 2005, in Michigan, California, Ohio, and Pennsylvania, half of children who lost coverage in Medicaid were reenrolled within two to three months (Fairbrother et al. 2007). In California alone, the state spent more than $120 million to reprocess eligible children that re-enrolled over a three-year period, between 2000 and 2003 (Fairbrother 2005).

Enacting provisions in the ACA will go a long way to simplify eligibility.

Several mandated provisions in the ACA will dramatically change how individuals enroll in and renew Medicaid coverage in Missouri. Currently, an individual begins the process at a local FSD office.[5] The application is completed by filling out a hard copy form with support from an eligibility specialist in the office.[6] On the application, clients are asked about assets, such as bank accounts or real estate, with documentation requested when deemed necessary. In a typical Missouri application

[5] At least one FSN office is located, by law, in every county of the state.

[6] Face-to-face interviews are not a requirement, but would typically happen. An application can be mailed with supporting documents, but the typical application is completed in person.

process, the client would also need to provide one or more recent pay stubs and proof of identify, such as a birth certificate or driver's license. Missouri requires 12-month renewals where enrollees will typically submit a signed renewal form either in person or by mail.

Under the ACA provisions, Missouri will be required to adopt **a "single, streamlined form"** for all insurance affordability programs and enable cooperation among the programs to ensure a **"no wrong door"** process. Applicants will be screened for eligibility for all three programs (Medicaid, CHIP and Exchange coverage) regardless of where they apply and will be referred to the appropriate program for enrollment, reducing the probability they are asked to submit multiple forms or have multiple eligibility determinations. Not only will individuals no longer need to know what program they are eligible for before applying, but this change will reduce duplicative administrative tasks. Indiana found that having a joint Medicaid/CHIP application form reduced printing costs and cut in half the time state workers spent verifying information (Wachino and Weiss 2009).

The ACA also requires states to provide multiple methods for accessing and submitting applications, including **online, in person, by mail, and by telephone**. This will be the first time that states are required to offer self-service online applications for Medicaid. Offering multiple pathways to enrollment outside county offices may be particularly important for the newly eligible population, most of whom will be working or live in working families who may have difficulty applying during conventional office hours, or are reluctant to apply for coverage in state "welfare" offices (Cohen Ross and Hill 2003; Rodman et al. 2011).

Many states, including Missouri, now allow individuals to apply for Medicaid or CHIP through web portals or online applications. Web-based enrollment can be an effective means for individuals to enroll in coverage for which they are eligible, while substantially lessening the amount of state resources needed to determine eligibility. It also helps mitigate the potential mismatch between the location of caseworkers and where the newly eligible reside. To promote the use of online enrollment, states should consider coupling this service with a variety of strategies designed to overcome barriers some populations have with applying online such as a need for real time assistance completing the application and access to computers.

Online accounts that allow individuals to apply for and renew coverage for public programs, report changes to their personal information, or ask questions, can promote beneficiary self-service and reduce the amount of time state eligibility staff managing case loads. Utah's "myCase" website offers customers an easy-to-use online account where they can access their benefit information and communicate with state eligibility staff at any time of the day (Brooks and Kendall 2012). The service allows individuals to opt to receive communication electronically, allowing notices to be sent directly to an individual's e-mail or phone. The service also allows individuals and state staff to communicate via online chat or though customized messages to assist customers with eligibility or technical questions or to communicate outstanding verifications.

For many individuals, smartphones are a gateway to Internet access. These devices allow individuals to connect to most websites on the Internet and have the capability to run applications designed to let the user perform specific tasks. Extension of web-based enrollment tools to mobile devices can broaden the accessibility of web-based enrollment pathways, and may be particularly useful in attracting some populations, such as younger individuals and minority populations (Brooks and Kendall 2012). The development of software applications for enrollment would offer individuals a secure, easy to use and efficient way to apply for or manage their benefits, at a convenient time and place (Han and Morrow 2011).

The ACA also largely **eliminates asset or resource tests** that many states use to determine Medicaid eligibility. Asset tests have been found to serve as a barrier to enrollment in public health insurance programs (Bansak and Raphael 2007; Smith et al. 2001). In an effort to simplify the application process and reduce the paperwork burden on eligibility staff, Missouri dropped the Medicaid asset test for children and parents with the implementation of CHIP in July 1998 (Smith et al. 2001). However, children in families with income above 150 percent of the FPL are subject to a "new worth" test (Heberlein et al. 2012).

The ACA also gives states the option of expanding the reach of **presumptive eligibility** policies. Under the current policy, "qualified entities," such as health care providers, can enroll children temporarily in Medicaid if their family income appears to be below state guidelines, giving families a certain length of time to complete the application process. This ensures that providers will be reimbursed for care for people who appear eligible for public coverage. Missouri currently allows hospitals and other federally-funded health clinics to offer presumptive eligibility in Medicaid to children and pregnant women. Under the ACA guidelines, it would have the option of expanding this to parents and childless adults, and the state currently has the option of extending it to children in CHIP (Brooks 2011). The ACA also gives hospitals that provide Medicaid services the prerogative to make presumptive eligibility decisions regardless of whether the state has adopted the option.

While presumptive eligibility policies hold promise, its potential as a strategy for Missouri brought mixed views from interviews with experts. Some viewed it as a critical part of any effort to enroll individuals; however, key Missouri informants pointed to the modest number of child enrollments facilitated with the current policy as evidence that it is unlikely to play a big role in enrolling newly eligible adults.

Expand administrative verification to reduce documentation requirements.

The ACA's vision for eligibility and enrollment is one in which existing third party data can be substituted for applicant-provided documentation. To make this happen, the ACA requires states' to match data electronically to third-party data systems for verification of eligibility, to the greatest extent possible. Ideally, state eligibility and enrollment systems would gather data from a broad range of external sources, including data currently used to verify income eligibility for Medicaid, federal income tax data, vital records, Social Security administrative data, and information from eligibility files of other need-based public benefit programs (Dorn 2010). Currently, Missouri does not use data to administratively verify income or match to Social Security Administration (SSA) data to verify citizenship (Heberlein et al. 2012).

Using third-party data to verify some eligibility criteria in lieu of providing documentation has many potential benefits including (1) reducing or eliminating the need for applicants to produce paper documentation; (2) reducing the processing time; (3) reducing human error due to data entry—all changes that can contribute to an increase in enrollment, lower administrative costs, and a more satisfying customer experience for applicants (Edwards et al. 2009). Research has not shown that simplification undermines program integrity, with error rates typically remaining low under paperless verification. A survey of state offices that have implemented self-declaration of income policies in Medicaid programs found that 8 of the 11 states had error rates of three percent or lower, and concluded that conducting third-party data verification helped states maintain low rates of eligibility error (Holahan and Hubert 2004).

States are required to obtain proof of citizenship from people who declare they are a U.S. citizen when applying for or renewing Medicaid and CHIP coverage, a requirement that can be particularly burdensome for both clients and staff (Cohen Ross 2007). States have had the option under Children's Health Insurance Program Reauthorization Act (CHIRPA) to conduct data matches with the SSA database to substantiate an applicant's claim of U.S. citizenship. States that have implemented this have been pleased with the system and have found it has several benefits, including easing documentation burdens on beneficiaries and providing states with administrative cost-savings (Cohen Ross 2010).

Some states have developed multisource data systems to help with verification and validation of income and assets in addition to citizenship, greatly streamlining the eligibility determination process. One such system is Utah's eFind, a web-based system that gathers, filters, and organizes information from 21 federal, state and local databases to obtain relevant application information, such as citizenship, income, and personal information. eFind, which cost the state $2 million to build, is expected to save $2.1 million each year due to improved staff efficiencies and productivity (Rodman 2011).

Oklahoma is the first state to implement a real-time Medicaid eligibility and enrollment system—SoonerCare Online Enrollment—that links an online application with an automated central rules engine and data exchange. Individuals can access the system at anytime and after entering basic personal information, a rules engine determines qualification for benefits, including SoonerCare (Oklahoma's Medicaid program). If individuals are deemed eligible, they receive on the spot SoonerCare enrollment, allowing immediate access to services. The state then verifies the individual's eligibility using data exchanges with the Social Security Administration, Oklahoma Employment Security Commission, child support services, and other state and federal agencies (Oklahoma Health Care Authority 2012). Prior to the online enrollment system in September 2010, individuals were required to apply in person at a county department of human service office or mail in an application, a process that could take up to a month to complete (Oklahoma Health Care Authority 2012). With SoonerCare Online Enrollment, the entire process can be completed in less than 30 minutes (Sheedy 2012).

Enact renewal simplification policies.

Under provisions of the ACA, states are required to adopt streamlined renewal procedures. Studies have generally found that state efforts to streamlining renewals have improved retention: a meta-analysis of studies across 22 states found that simplified renewal procedures appear to increase retention in CHIP (Rosenbach et al. 2007). These strategies include:

12-month continuous eligibility for children:[7] Under a policy of 12-month continuous eligibility, states provide a year of guaranteed coverage after enrollment, regardless of whether changes in income or family structure affect a child's eligibility for the program. While continuous eligibility is unlikely to significantly increase take-up of coverage, it is expected to increase the stability of children's coverage by reducing discontinuous coverage due to temporary fluctuations in

[7] States have the option to provide 12-month continuous coverage to children in Medicaid and CHIP. The ACA does not extend this option to adults. States can only provide this to adults under a waiver.

income or the complexities associated with ongoing eligibility verification processes (Irvin et al. 2001).

Continuous eligibility has been found to improve retention in Medicaid. After California extended their Medicaid eligibility redetermination period from 3 to 12 months, 62 percent of children were continuously covered for two years following the extension, compared to only 49 percent for the two years prior to the extension (resulting in an estimated 1.4 million additional months of Medicaid coverage) (Bindman et al. 2008). Continuous eligibility has also been associated with lower administrative costs due to reenrollment. When Washington shifted children's certification periods from 12 to 6 months in 2003, administrative costs rose by $5 million (Ku et al. 2009).

Preprint renewal applications*:* With preprinted applications, states use information from the prior application or from another data source (for example, information from a more recent Supplemental Nutrition Assistance Program (SNAP) application to populate the renewal application, sending it to the enrollee to verify and sign. Individuals are asked only to indicate changes and submit verification for items that have changed. Using prepopulated forms not only makes the process less burdensome for enrollees, it can reduce administrative followup to correct errors or incomplete applications (Courtot and Coughlin 2012).

Rolling Renewal: Some states provide individuals an option to renew coverage at times other than the usual renewal period. This option gives households more flexibility to renew at a time that is convenient for them, and allows for better coordination with renewals for other public programs (Cohen et al. 2008).

Administrative and ex parte renewal: Administrative renewal, in which the state assumes eligibility in the absence of information indicating otherwise, and ex parte renewal, in which a state determines eligibility from available data, and not the applicant, enable redetermination of eligibility with minimal or no action required from enrollees. These "passive renewal" policies change the default action to continued coverage, rather than disenrollment, for those who do not respond to renewal notices (Cohen Ross and Hill 2003). This eliminates a step that serves as a major barrier to many individuals; one study found that as many as 40 percent of children lost their CHIP eligibility at renewal because their parents never responded to notices informing them of the need to renew (Hill and Lutzky 2003).

Louisiana has taken a series of innovated steps to streamline the renewal process and prevent children from losing coverage due to paperwork that can serve as a model for retention policy (Brooks 2009). Rather than having a renewal process that typically involves the submission of a renewal form, the state utilizes administrative renewals, ex parte reviews, rolling renewals, and phone and internet renewal options for the vast majority of all renewals. After enactment of these changes, the percentage of children lost at renewal dropped from 28 in 2001 to 8 percent in 2005 (Cohen et al. 2008). Currently, less than one percent of children are not renewed for procedural or administrative reasons. Moving to a paperless renewal processes has generated significant administrative savings for Louisiana. By eliminating printing and postage costs and reducing the manpower needed to process outgoing and income forms, Louisiana estimates they save $18.95 million annually from paperless renewals (Penny Chapman, personal communication, August 9, 2012).

Use data to automatically enroll individuals who meet program eligibility criteria.

Leveraging data from existing sources to automatically enroll individuals newly eligible for Medicaid could result in a large-scale influx of newly eligible individuals (Dorn 2009). Many individuals who will be newly eligible for Medicaid or other programs are already known to state systems because they previously applied for Medicaid coverage, their children are enrolled in Medicaid, or they aged off Medicaid, and therefore, information needed to assess their eligibility is already held by the state Medicaid agency. Others are receiving human services benefits from another agency that retain income and other information needed to determine eligibility for Medicaid.

Auto-enrollment using information in Medicaid data system: In Missouri, approximately 331,629 nonelderly adults will be made newly eligible for Medicaid coverage under a Medicaid expansion with another 300,000 who will be eligible for premium assistance. Even without full take-up, it is likely a majority of these individuals will apply for coverage and need to have their eligibility determined by the state. Missouri's Medicaid agency could proactively investigate those already in their system to see if they qualify for benefits under the state's new income guidelines and enrolling them if so. States that have used such a process to jumpstart enrollment following expansions include:

- As part of its BadgerCare plus expansion, **Wisconsin** conducted a one-time auto-enrollment of previously ineligible individuals for which the state had current information in their eligibility database. These cases included individuals with at least one family member currently enrolled in the state health program or individuals whom been disenrolled prior to launch of the expansion (DeLeire et al. 2012). Applying the new program criteria to these cases resulted in 42,000 people newly eligible on the first day of the program, most of them older siblings, caretakers, and relatives of current enrollees (Hynes et al. 2010).

- **Massachusetts** similarly used information collected from its uncompensated care program to "auto-convert" people into the Commonwealth Care program for which they were eligible, without any need for the individuals to complete new application forms (KFF 2012a). One year into the program, nearly 100,000 former uncompensated care program members were enrolled in CommCare, presumably through the auto-conversion process (Dorn 2009).

Leveraging information in states' human service data systems: Another promising strategy for identifying and enrolling newly eligible individuals in Medicaid calls for states to use existing data sources and develop a streamlined process for verifying eligibility. If individuals have authorized data sharing with Medicaid, information held by public programs such as SNAP and Temporary Assistance for Needy Families (TANF), the Low Income Home Energy Assistance Program, and work support programs could be shared with the state Medicaid agency to help identify eligible people and begin the enrollment process (Morrow and Paradise 2010). Given that many of the households served by these and other human service programs will be eligible for Medicaid and premium assistance under an expansion, the use of technology to share data across programs offers great potential.

VI. LESSONS LEARNED

In previous CHIP expansion efforts, Missouri developed a comprehensive strategy with a strong focus on partnerships with community-based organizations to increase awareness and facilitate enrollment. Committed state leadership, strong working relationships with other agencies and community partners, and foundation support created greater program awareness, and contributed to the success of Missouri's implementation of CHIP. An expansion of Medicaid to low-income childless adults in Missouri can build on the foundation of these previous efforts, along with adapting successful strategies from other states' experiences to address the unique challenges and opportunities to reach and efficiently enroll this population. Here we highlight specific strategies for Missouri to consider.

Utilize its network of community-based organizations, foundations, and provider groups to drive a comprehensive eligibility awareness effort.

A comprehensive expansion effort will require a combination of strategies to target different segments of the uninsured population. An initial statewide media campaign to build program awareness and direct people to an online resource may be effective in reaching some subgroups, but states, including Missouri, have also found that mass media campaigns are expensive and difficult in targeting eligible populations. Missouri's low-profile grassroots approach in the CHIP expansion proved highly effective and served as a national model. This should be the backbone of any outreach campaign to support a Medicaid and premium assistance program expansions.

Community-based promotion can bring targeted messages to local populations to reach specific newly eligible groups. Community partners provide a trusted local voice to reinforce messaging, offer detailed program information, answer questions, and facilitate enrollment. Social media offers a promising new approach that can be tailored to targeted audiences throughout an expansion effort.

Engage the private sector to support eligibility awareness efforts.

Private sponsorship can supplement state and community-based eligibility awareness efforts to reach eligible individuals in new ways. Grocery stores, pharmacies, fast food restaurants, convenience stores, and large employers can be tapped to help advertise new coverage opportunities and distribute informational materials. Health plans played an important role in Missouri's CHIP outreach efforts, doing extensive marketing of the program through television and radio ads and billboards.

Develop clear messages that resonate with low-income, uninsured adults without dependent children to effectively convey eligibility for Medicaid and the program's benefits.

Use of new descriptive program names, promotional materials featuring representatives of target populations, multilingual marketing, and in-person contact with community-based partners can increase program awareness among diverse groups of eligible individuals. Messages should be simple and received multiple times from multiple sources by the target population. Hard-to-reach subgroups will require greater targeted messaging delivered by trusted community-based organizations. Messages that resonate with low-income uninsured adults include describing coverage as "low-cost or free" (versus "affordable"), highlighting the most valued covered services including hospitalizations, checkups, and prescriptions, and emphasizing the financial protection that health insurance offers.

Develop a broad range of enrollment access points to move the application process out from county offices.

Web-based application platforms will likely be the backbone of states' enrollment systems moving forward. However, not all individuals will feel comfortable applying online, and others will require help to do so or have questions about the program or coverage options. Key informants stressed the importance of taking the application process to the target population. Community-based outreach workers, providers, and private companies will play a critical role in making individuals aware of their eligibility and motivating them to enroll in the program. Missouri can further enable these partners to assist with the enrollment of individuals by allowing them to play an active role in the application process.

Whether the vehicle to create such a role is through the Exchanges (as navigators) or state agency authority, Missouri should begin by:

- **Enlisting the support of community partners who serve low-income adults.** Missouri has begun to identify the uninsured population targeted under an expansion and has a strong network of community partners willing to collaborate in a statewide eligibility awareness effort. Establishing working relationships with community-based organizations that serve low-income adults and enabling them to assist with the application process would help reach this population. Recommended venues include unemployment offices, SSI agencies, food stamp offices, food banks, job training programs, career centers, job fairs, housing assistance programs, churches, homeless or domestic abuse shelters, and literacy/GED programs. Both the Health Care Foundation of Greater Kansas City and the Missouri Foundation for Health have expressed the desire to support the ongoing needs of community organizations to increase their capacity in support of Medicaid and premium assistance expansions.
- **Encourage participation of health care providers in a collaborative integrated outreach effort.** Providers can play a key role in an expansion effort. They have contact with uninsured individuals when they seek care, and low-income adults believe health care facilities offer an appropriate setting for education about coverage options and enrollment assistance. In Missouri, the Gateway to Better Health demonstration project illustrates the role of community health centers in reaching eligible adults through established relationships in their communities and facilitating enrollment. These local providers offer a trusted source to deliver targeted messages and counter conflict between people's distrust of the government and desire for health care coverage.
- **Setting up a centralized phone center to handle questions and renewals.** As part of its overall enrollment strategy for the CHIP expansion, Missouri added seven regional phone centers to provide enrollment assistance, and many believe the phone centers were a valuable component to the state's overall enrollment strategy. Missouri could consider authorizing such a phone center to do renewals, an option that draws high marks from both beneficiaries (Lake Research Partners 2009) and state caseworkers (Brooks 2009) for its simplicity and accuracy.

Simplify, simplify, simplify.

The message we heard from the vast majority of our key informants was that without dramatic simplification of eligibility determination during both enrollment and renewal, states are unlikely to be able to manage the demand placed on their eligibility systems. Key informants from other states told us that the best way to make the enrollment process more efficient is to "do everything CMS allows you to do."

The simplification provisions required by ACA will move Missouri a good deal closer to a 21st century eligibility and enrollment system, however, states will have some latitude in how they implement some of them. States like Wisconsin and Louisiana serve as examples for developing a comprehensive model for simplifying the Medicaid enrollment and renewal process. Common strategies used by these and other states include: (1) moving away from documentation requirements by allowing applicants to self-declare key eligibility criteria; (2) allowing enrollees to renew eligibility on a rolling basis; (3) allowing caseworkers to apply reasonable certainty verification, where enrollment or renewal is processed if eligibility worker is "reasonably certain" the individual is eligible; (4) accepting applications and renewals in a variety of formats, with a concerted effort to move away from paper-based applications; (5) moving to "passive" processes for enrollment and renewal where possible; and (6) using third-party data to verify eligibility criteria.

A key component of a comprehensive strategy to simplify the enrollment process for both applicants and eligibility workers is to ***use available data as evidence for eligibility instead of paper documentation.*** Over 330,000 individuals will be made newly eligible for Medicaid in Missouri if the state moves forward with a Medicaid expansion as outlined under the ACA. Additionally, the expansion is likely to have a significant "woodwork" effect, whereby individuals currently eligible but uninsured will enroll in Medicaid. Based on some estimates of the newly eligible, the workload of state caseworkers is expected to increase 1,000 percent (Becker et al. 2012). Missouri will need to look for ways to maximize the efficiency of its eligibility system to process enrollment and renewals, and should look to base eligibility determinations on data that is already available to the state, whenever possible. Other states have found that moving to paperless processes by using third party data can make determinations quicker, reducing the burden on individuals and families seeking coverage, as well as the administrative burden on agencies.

Additionally, Missouri could look for opportunities to ***automatically enroll newly eligible individuals.*** One way to reduce the number of applications Missouri will need to process after the start of an expansion would be to proactively auto-enroll individuals that are currently known to the Medicaid "system," but are ineligible for coverage under current law. Wisconsin and Massachusetts used such an approach to quickly extend coverage to a large number of newly eligible individuals. One study used the American Community Survey to estimate the number of parents nationwide who could potentially be auto-enrolled into Medicaid under an expansion. For Missouri, almost half of the parents estimated to be newly eligible under an expansion had children on Medicaid or CHIP (DeLeire et al. 2012). The state can also assess the feasibility of coordinating eligibility across health and human services programs and data systems.

Promote a culture of coverage.

Research and experts underscore the importance of state leaders to develop, communicate, and execute a vision to expand health insurance coverage to low-income uninsured adults (Wachino and Weiss 2009). A successful coverage initiative will depend, in large part, on effective collaboration between state agencies and a reorientation of Medicaid management, its systems, and caseworker

training away from welfare-style "gatekeeping" and toward encouraging participation. Having high-ranking leaders champion a coverage expansion can help facilitate the necessary cooperation among state agencies and reinforce the need to move to a customer-centered eligibility process.

High ranking leaders not only set the agenda, but also identify the challenges faced at the local level and commit the necessary resources to help enable local staff and partners meet the goals of the initiative. In Wisconsin, the governor included coverage for adults without dependent children in the state budget. Legislators passed the budget, and agency leaders had a lot of latitude regarding how to fashion the federal waiver. Missouri's CHIP program enjoyed strong political support—state political leaders advocated for expanding access to health insurance and state agency leaders were committed to extending resources to expand coverage and facilitate enrollment. Some Missouri informants indicated that one key to the success Missouri enjoyed with its CHIP expansion was state leadership sending a message that "we want you to have health care" and anticipating and meeting numerous implementation challenges along the way. In the absence of state leaders promoting a culture of coverage, local leaders may be needed to fill the void, not only in promotion of coverage, but also in the commitment of resources needed to enable the many motivated stakeholder groups across the state.

The culture and stated priorities of the Medicaid agency can have a meaningful impact on how successful states are in reaching coverage goals. Having a culture that promotes coverage has been identified by states that have enacted enrollment simplification measures as a critical component of any comprehensive enrollment strategy (Weiss and Grossman 2011). Agency caseworkers are the individuals who put into practice many of the streamlined procedures, such as use of third party data or administrative renewals. When asked how much of their recent success in enrolling and retaining children in Medicaid was due to having undergone a shift in agency culture, one state suggested it "would have been impossible" without eligibility staff buy in.

States may need to introduce changes in policies, local office procedures, and incentives to align the eligibility process with coverage priorities (Paradise and Perry 2010). To do so, states have taken a variety of approaches, such as giving local offices the authority to make decisions on how to conduct outreach in their communities, rewarding caseworker efforts to enroll or retain coverage, and realigning worker expectations to promote coverage (Rosenbach et al. 2007; Wachino and Weiss 2009). Including staff at the table when developing new eligibility systems and implementing new policies will be important to get their buy in regarding the system changes, as well as to ensure staff understands the importance of their roles and responsibilities under the new system (Courtot and Coughlin 2012).

Build it before they come!

Two messages that almost every informant stressed to us was that states should develop a comprehensive approach to making the enrollment process successful and they need to have that approach in place *before* individuals start enrolling. Adopting presumptive eligibility without streamlining the enrollment process, promoting a "new Medicaid program" without changing the experience customers have when applying for coverage, or making individuals eligible for a program that is difficult to enroll in or does not lead to services, are experiences that will feed into the negative perception that many people have of Medicaid, or government run programs in general. "You only have one chance to make a good impression" was the message that many informants stressed. In preparation of an expansion, training partners who will be the "face" of any outreach effort—such as staff from CBOs, clinics, and human services departments—is crucial to making sure potential enrollees are provided with helpful assistance and accurate information. This is

something Missouri has had success doing in past expansions and will serve as a model for this Medicaid expansion.

With its Gateway to Better Health demonstration program, Missouri has already started the process of reaching out to those who will be newly eligible and working with CBO's serving this population. As a way to proactively build partnerships with providers and CBOs in other parts of the state in preparation for a Medicaid and premium assistance expansion, Missouri could obtain waiver authority to expand Medicaid to adults on a limited basis, similar to Colorado's approach described earlier. The state will similarly need to start preparing for the changes in how it will conduct Medicaid eligibility determinations for individuals and families, and design and plan training for agency staff on new policies, procedures, and tools. This will allow time to solicit feedback to ensure the process works for both clients and the staff that will carry out the new processes.

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APPENDIX A

KEY INFORMANTS

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Appendix A. Key Informants

Name	*Title*	*Relevant Experience*
Missouri Informants		
Ryan Barker	Director of Health Policy Missouri Foundation for Health	Foundation serves St. Louis area; leads health policy division focused on affordable coverage for all Missourians
Marilynn Bradford	Former Associate Director Missouri Department of Social Services	Coordinated Missouri CHIP expansion
Donna Checkett	Director, State Government Affairs Aetna, Inc.	Former Medicaid Director during Missouri CHIP expansion
Dwight Fine	Former Senior Vice President of Governmental Relations Missouri Health Association	Consulted with Missouri Department of Social Services on HIE implementation and electronic enrollment and eligibility systems
Robert Freund	Chief Executive Officer St. Louis Regional Health Commission	Leads "Gateway to Better Health" project in St. Louis, MO
Lane Jacobs	Outreach Program Manager Missouri Primary Care Association	Medicaid outreach and application assistance, CHIP expansion in MO
Daniel Landon	Senior Vice President for Governmental Relations Missouri Hospital Association	Manages the Missouri Hospital Association's federal and state legislative and regulatory advocacy functions
Steven E. Renne	Vice President of Children's Health and Medicaid Advocacy Missouri Hospital Association	Former Director of Missouri's Medicaid program
Steve Roling	President, CEO Health Care Foundation of Greater Kansas City	Foundation serves Kansas City area; focused on healthcare for the uninsured
State and National Informants		
Tricia Brooks	Senior Fellow Georgetown Center for Children and Families; Assistant Professor Georgetown University Health Policy Institute	National expert on policy and implementation issues affecting coverage for children and families; former NH CHIP director and CEO of NH Healthy Kids Corporation.
Penny Chapman	Manager Louisiana Department of Health and Hospitals	LA Medicaid enrollment process improvement
Vicki Grant	Vice President The Southern Institute on Children and Families	National expert on increasing efficiency and effectiveness of public benefit programs through process improvement
Lori Grubstein	Program Officer Robert Wood Johnson Foundation	Responsible for the Covering Kids and Families program
Jim Jones	Senior Consultant Sellers Dorsey	Former Wisconsin Deputy State Medicaid Director; responsible for implementing BadgerCare Plus
Michael Perry	Partner Lake Research Partners	National health policy expert; focus on public health programs, health care reform, issues related to the uninsured

Table Continued

Name	*Title*	*Relevant Experience*
Linda Schumacher	Former SCHIP Coordinator, Division of Policy and Provider Services Maine Department of Human Services	ME Section 1115 waiver Medicaid expansion to low-income childless adults
Chad Shearer	Deputy Director Robert Wood Johnson Foundation's State Health Reform Assistance Network	Leader of RWJ state network effort evaluating 10 states implementing ACA expansions
Andy Snyder	Policy Specialist National Academy for State Health Policy	Policy specialist working on RWJ's Maximizing Enrollment project
Alice Weiss	Program Director National Academy for State Health Policy	Co-director of national initiative to help states increase and promote best practices for enrollment and retention of CHIP and Medicaid children
Judy Zerzan	Chief Medical Officer and Deputy Medicaid Director Colorado Department of Health Care Policy and Financing	CO Medicaid Director

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