Missouri Foundation for Health

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t. Louis, MO 6311

2. Characteristics and needs of newly eligible populations (e.g., number, demographics, geographic distribution, health issues/care needs, and current health care coverage)

3. Capacity of the health care system to respond to predicted demand (e.g. number of primary care providers, capacity of facilities and managed care systems, availability of relevant specialties, relationship between system capacity and where new bene ciaries live and will demand services)

4. The role of social determinants (e.g., socioeconomic status, race, gender, ethnicity, English language uency, involvement in criminal justice system) on awareness of eligibility, access to enrollment opportunities, and likelihood of receiving quality care

5. Inter-related impacts of the recession and COVID-19 on numbers and needs of those eligible for Medicaid expansion (e.g., rising need for mental and behavioral health services, increasing housing and employment insecurity)

The ndings of this research – and possibly more research questions as they arise – will be shared with the MEP through the research project team to guide conversations on implementation.

Integrating Existing Networks

The MEP's care delivery system and consumer experience project teams will focus on how implementation may impact where, how, and by whom care is delivered as well as the opportunities and barriers experienced by individuals as they enroll and access care. These two teams will bring their knowledge and expertise from the eld to inform the best path forward. In addition, the existing Cover Missouri Coalition will serve as a valuable entity related to care delivery and consumer experience, particularly as outreach and enrollment activities increase.

Methods of Gathering Information from Other States

To maximize the usefulness of the experiences of other expansion states, data was gathered from various resources using search engines like PubMed and Google Scholar and summarized and synthesized here. All resources used in the development of this literature review are listed at the end of the document. The resulting information has been organized into three sections below - administration/systems, enrollment systems/outreach, and campaigns/marketing - to promote easy accessibility by the various MEP project teams.

Key Findings

Administration/Systems

In order for Medicaid expansion to be e ectively implemented, certain administrative systems need to be in place. These system considerations include required actions by the state to set up eligibility guidelines for the expansion population, enrollment system improvements, and administrative infrastructure. Much of this section contains information that will be outlined in the playbook, though the MEP can play a role by drawing on their own expertise and experience, as outreach and enrollment are both a state and stakeholder function.

What does the governmental body need to do?

- The ballot initiative requires the state to submit necessary state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) by March 1, 2021. SPAs are e ective retroactive to the rst day of the quarter in which the state submits the amendment, giving Missouri some exibility if an SPA is not approved by CMS prior to the July 1, 2021, implementation date mandated by the ballot initiative (e.g., an SPA submitted on March 1 and approved by CMS on August 1 is deemed e ective beginning back on January 1.) The playbook will cover the details of the SPAs required for submission.

- Other considerations of the governmental body, discussed in the playbook, include:
  - Cross-agency coordination
  - Enrollment facilitation
  - Organizational structure for implementation
  - Technical and other implementation hurdles
  - Collaborative stakeholder engagement process
  - Budget o sets, savings, and revenues for program nancing

What are opportunities to improve enrollment and eligibility systems?

- Integrated applications*: States have developed integrated applications for Medicaid that make the process simpler for applicants.
  - Kentucky integrated all application processes (including the Marketplace) with one address and telephone

Synchronize reenrollment for parents and children
Automatic renewals
12-month continuous eligibility

**These are also recommendations from the Civilla project of MFH and the state.*

What are opportunities to improve infrastructure?

- Determination v. Assessment states: States have the exibility to determine how their Medicaid agency and marketplace will coordinate, depending on whether the state has opted for a state-based (SBM), state-partnership (SPM), or federally facilitated marketplace (FFM).
  Determination states – the SPM or FFM makes the nal Medicaid eligibility determination and transmits this determination to the state Medicaid agency
  Assessment states - the SPM or FFM makes an initial assessment of eligibility for Medicaid, and the state Medicaid agency makes the nal Medicaid eligibility determination
- Louisiana successfully transitioned to a "determination" state from an "assessment" state. Louisiana recommends that this should be done as soon as possible for states interested in speeding up eligibility determinations and enrollment. West Virginia also chose to be a determination state after completing a cost-bene t analysis that showed their processes would be simpli ed and burdens reduced for state Medicaid administration sta . Arizona opted to be an assessment state, which allows the state to maintain contact with Medicaid-eligible people and refer them to social services upon assessment.
- Missouri is an assessment state and relies on the FFM, meaning the state makes the nal eligibility determinations based on the assessment from the FFM. An SPA is required to change to a determination state.

What relationships should be built with the legislature and other government o cials?

- Buy-in from state: Louisiana notes how important the support of the governor and top state o cials was in the adoption of expansion. Additionally, they hired a Medicaid Expansion Project Director as a dedicated resource to give transition "undivided attention." If a person like this is appointed in Missouri, this could be a relationship building opportunity for the MEP.
  Lessons from other states echo this sentiment. Commitment from the governor, state o cials, and stakeholders (attended local level enrollment events, etc.) created a "culture of coverage" in the state. Collaboration across state agencies was important, along with community, advocates, and providers (early engagement, regular meetings, ongoing information sharing). Successful states found it important to keep state o cials updated on coverage processes with data to show progress at district level.

Enrollment Assistance/Outreach

One major consideration of the state will be how to conduct enrollment of the Medicaid expansion population. The members of the MEP could provide input on how stakeholders engage in enrollment activities and outreach. This section outlines some of the opportunities to improve the consumer experience of enrollment and to ensure that enrollment is equitable, e cient, and e ective by using examples from other states.

How will consumers experience enrollment?

- Consumer friendly enrollment systems: States have implemented various tools for enrollment systems that are easy to use, including pre-screen for eligibility, electronic upload of documents, and local resources available to search. Some states have also used mobile-based options or apps for enrollment.
- Funding for enrollment assistance: Stakeholders may need funding to conduct enrollment assistance. States have invested in enrollment using various mechanisms. Kentucky awarded $6 million in grants to organizations for sta to assist consumers during open enrollment (leveraged community relationships and support of leaders). Kentucky also opened "storefronts" to o er in-person enrollment in communities with low enrollment. Arkansas leveraged federal funding to support organizations to train assisters, who became certi ed (via ACA guidelines) to provide enrollment assistance.

- Eligibility “outstationing”: Outstationing, providing enrollment opportunities at areas outside of the designated facilities, allows eligibility workers to reach more of the Medicaid expansion population. States recommend maximizing eligibility outstationing throughout the state by stationing eligibility workers at FQHCs, welfare o ces, and other similar locations to ensure maximized enrollment. According to CMS, states are required to allow pregnant women and children opportunities to apply for Medicaid at locations other than welfare o ces, including FQHCs.

- Back-to-school outreach e orts: Many parents of children enrolled in Medicaid and CHIP will be eligible for Medicaid coverage with expansion. As a result, schools can be a vital place to conduct outreach. During the COVID pandemic, states are being creative in their outreach e orts. Kentucky, for example, has set up drive through school events where professional outreach workers can distribute materials and speak with families. Additionally, Virginia has created online widgets that integrate into school websites and have set up text campaigns to reach parents and encourage enrollment.

- Capacity for outreach: Building capacity for outreach is extremely important for enrollment strategies. The Cities Expanding Health Access for Children and Families project helped cities build capacity to conduct outreach and enrollment for Medicaid and CHIP. To be successful, cities needed to leverage existing partnerships with community organizations, plan for data collection from the outset, build campaigns around evidence-based practices, and develop strategies to institutionalize e orts.
    Note: The Virginia Health Care Foundation created a toolkit for Medicaid enrollment sta as a training guide. MFH has a copy of this training manual/toolkit on hand for MEP members to read or use as a reference.

- Additional best practices for enrollment assistance:
    Personalized, one-on-one assistance through trusted individuals in the community
    Using state funds in addition to federal sources to increase capacity
    Coordination among assisters (some have tied into existing systems like United way 211)
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Local enrollment events
Walk-in storefronts or temporary enrollment sites (mobile enrollment vans)
Targeting hard to reach communities (Hispanic, Black, immigrants, LGBT, young adults, veterans)
Personal testimonials that emphasize a ordability and bene ts and directs to resources

Additional Best Practices

Aside from the ndings of the rest of the literature review, this section adds a few additional relevant best-practices from other state experiences.

Planning considerations: Day-one readiness was crucial for Louisiana's transition. Before launch, the state engaged in volume testing and rapid response planning as well as developing a strategy for rapid enrollment. Louisiana also worked to get buy-in from Medicaid providers and provider associations. Additionally, the state made sure that di erent systems contractors were coordinating during development of enrollment systems and plans. This is again primarily a function of the playbook contractors. Lastly, in order to get public buy-in, Louisiana created a web-based dashboard to show the bene ts of expansion.

Hybrid clinics: In Virginia, many free clinics became "hybrids," continuing to treat uninsured patients while also becoming Medicaid providers. This increased the availability of providers to be able to see the hundreds of thousands of new Medicaid patients after expansion.

Lessons learned from early expansion states: Interviews with early-expansion states (California, Connecticut, D.C., Minnesota, New Jersey, and Washington) revealed several lessons:

Lesson #1: Many Medicaid expansions are occurring in states with pre-existing state health insurance programs for low-income adults. This causes administrative challenges for transferring adults from one form of coverage to another.

Lesson #2: Expansion-related predictions are challenging. Predictions of cost and enrollment can vary signi cantly, thus causing unexpected outcomes – should be prepared for wide range.

Lesson #3: Barriers to coverage and access remain, even after expanding eligibility. Di culty enrolling very low-income and keeping bene ciaries enrolled due to transiency (culturally competent outreach using community-based providers helped). Care coordination in fee-for-service Medicaid was also a concern (shortage of providers in rural areas).

Lesson #4: Behavioral health is a critical need for Medicaid-eligible population.

Lesson #5: Expansion required signi cant administrative e orts to implement, including hiring more sta , transferring bene ciaries, and handling an increased volume of applications.

Lesson #6: Outreach around expansion may create a "welcome mat" e ect, in which individuals who were eligible, but not enrolled in Medicaid before expansion, choose to enroll in the program. The state does not receive the enhanced 90% Medicaid FMAP for these bene ciaries.

Lesson #7: Political context matters a great deal in implementing a Medicaid expansion. All six of the early expansion states had supportive governors and "pro-coverage" culture.