

Medicaid Expansion in Missouri: Promising Approaches and Key Lessons from Other States

Background Information

Missouri is the 38th state to expand Medicaid and the sixth to do so by ballot initiative, so there is a lot that can be learned from previous successful implementations. Although voters approved the ballot initiative, it is now up to state officials to implement Medicaid expansion. Stakeholders, advocates, and other partners across the state are coming together to help support an efficient, effective, and equitable implementation. This document compiles promising approaches and key lessons learned from other states in order to inform stakeholders involved in implementation efforts. The Medicaid Expansion Planning group (MEP), formed by Missouri Foundation for Health (MFH) in partnership with Health Forward Foundation (HFF), can use this information to guide their approach as well as identify gaps where further research and attention may be necessary.

Medicaid Expansion Planning Group

The Medicaid Expansion Planning (MEP) group is comprised of stakeholders, providers, advocates, and others that have joined MFH and HFF to advance their vested interest in supporting an efficient, effective, and equitable implementation of Medicaid expansion in Missouri. The project teams of the MEP include: state systems, care delivery system, consumer experience, research, and advocacy. The advocacy team is run by Health Care for Missouri while the overall MEP group and the other project teams are being led by MFH with strategic guidance from HFF.

The Medicaid Expansion “Playbook”

The “playbook” refers to a contracted report by Manatt Health commissioned by MFH that distills the experiences of other expansion states to provide an implementation guide for the Department of Social Services (DSS), the agency that administers MO HealthNet. It will serve as a blueprint to guide DSS on issues such as necessary state plan amendments (SPAs), effective strategies for outreach and rapid and accurate enrollment, impact on other state programs, information technology and programming needs, methods to maximize budget offsets and savings, and collaboration with managed care organizations, health care providers, and other stakeholders.

Manatt Health will work alongside the MEP by providing insights from their research to better inform stakeholders and by gathering relevant information from MEP members to better inform the playbook. While the playbook is primarily a tool for the state, it will also be valuable for MEP members, chiefly those serving on the state systems project team, to more fully understand the expansion process at this level and hold the state accountable if implementation activities stall. Many of the questions outlined in the “Administrative/Systems” section will be answered in whole or in part by the playbook, but collective strategizing and action from the MEP will be critical to successful implementation.

Missouri-Specific Expansion Research

In order to fill in gaps in knowledge of Medicaid expansion implementation in Missouri, MFH is commissioning further research into the following topics:

1. Enrollment (e.g., What might we expect in Missouri in terms of rate and modalities of new enrollment? What are the implications of various scenarios for how providers and facilities should prepare in terms of capacity and fiscal sustainability? How might enrollment rates change with or without the participation of advocates or a Cover Missouri Coalition strategy?)

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 beneficiaries live and will demand services)
4. The role of social determinants (e.g., socioeconomic status, race, gender, ethnicity, English language fluency, 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 findings 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 field 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 effectively 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 effective retroactive to the first day of the quarter in which the state submits the amendment, giving Missouri some flexibility 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 effective 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 offsets, savings, and revenues for program financing

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 helpline and released a mobile app. Arkansas allowed applications through federal (healthcare.gov) and state means (Access Arkansas). Arkansas outsourced eligibility determination of the federal applications to CMS.
- Seamless transfer of eligible participants: States set up ways to automatically transfer certain Medicaid program participants to the expansion group when they are eligible.
 - Louisiana seamlessly transferred newly eligible enrollees from their previous coverage programs. This process included: mailing notices to program participants before they were transferred, facilitating other enrollment using SNAP data (many of which did not require an additional Medicaid application), and using a SNAP-assisted enrollment strategy for renewal procedures, saving time and money.
- SNAP eligibility: Multiple states have successfully used “Fast Track” eligibility checks which involves using SNAP rolls as a method to identify potentially eligible households.
 - Louisiana did this to identify those who are “certain” to be eligible. This involved submitting an SPA under guidance from CMS. This allowed eligible people to opt into Medicaid instead of applying, reducing administrative burden.
- Presumptive eligibility: During the COVID-19 pandemic, several states implemented expanded presumptive eligibility (PE) processes. These processes include broadening who is a “qualified entity” to conduct PE determinations, allowing entities to determine PE for all groups, loosening standards on hospitals that perform PE, and encouraging PE providers to help clients submit full Medicaid applications to continue coverage.
 - The public health emergency (PHE) allows flexibilities regarding presumptive eligibility policy. Under these PHE flexibilities, Kentucky has enrolled over 137,000 individuals under presumptive coverage by designating the state Medicaid agency as a qualifying entity to determine presumptive eligibility. This is done based on individuals modified adjusted gross income and by condensing the 20-page application into one short online form. Once their eligibility period ends, Kentucky Medicaid agents track these applications to identify when individuals’ PE periods are ending. They then make direct outreach calls to these enrollees to assist them in completing a full Medicaid application.
 - This process could end with the public health emergency, though states may explore keeping these changes permanently. This is something that should be tracked once the emergency subsides.
- Unemployment applications: States have also leveraged interagency partnerships to target their outreach strategies to individuals who may be eligible for Medicaid coverage.
 - To connect with individuals who may have lost employer coverage due to the pandemic, both Kentucky and Virginia have contacted thousands of individuals who have applied for state unemployment insurance. The states also added easily accessible links to their unemployment agency websites to help individuals apply for health coverage.
- Other considerations:
 - Consumer-friendly features of enrollment systems (pre-screen for eligibility, electronic upload of documents, and local resources available to search)*
 - Mobile-based options or apps for enrollment*
 - Express-lane eligibility
 - Use of child enrollment data to identify potentially eligible parents

- 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 flexibility 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 final 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 final 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-benefit analysis that showed their processes would be simplified and burdens reduced for state Medicaid administration staff. 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 final 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 officials?

- Buy-in from state: Louisiana notes how important the support of the governor and top state officials 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 officials, 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 officials 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, efficient, and effective 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 staff to assist consumers during open enrollment (leveraged community relationships and support of leaders). Kentucky also opened “storefronts” to offer in-person enrollment in communities with low enrollment. Arkansas leveraged federal funding to support organizations to train assisters, who became certified (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 offices, 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 offices, including FQHCs.
- Back-to-school outreach efforts: 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 efforts. 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 efforts.
 - Note: The Virginia Health Care Foundation created a toolkit for Medicaid enrollment staff 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)
 - Providing dedicated phone lines to assisters for real-time assistance with enrollment issues (some use Medicaid agency)
 - Training for assisters to learn new eligibility rules, answer consumer questions, and help navigate applications
 - Expanding call center capacity to meet increased need during initial year
 - Engaging provider community in outreach by utilizing patient relationships to insure the people they already serve (“in-reach”)
 - Note: It will be important to leverage existing resources and stakeholder networks to accomplish these best practices in Missouri (e.g., Cover Missouri Coalition)

Campaigns/Marketing

Some states have used marketing campaigns to inform the public about the expansion of the Medicaid program. The MEP could help organize various campaigns and marketing efforts to educate the public on expansion and the importance of implementation. This section includes examples from other states that have utilized campaign efforts.

What are best practices for an outreach campaign?

- Outreach campaigns: States have implemented various modes of technology and advertising in their campaign efforts. A Kentucky campaign included TV advertisements, Internet, billboards, and buses to increase awareness of coverage options and how to apply. The Medicaid program also participated in information booths at the Kentucky state fair and other events to reach a wider population. An Arkansas campaign included TV, radio, newspapers, billboard, direct mail, and internet and hired trained speakers at engagements across the state.
- Additional best practices for marketing efforts:
 - Note: Existing communication mechanisms could be utilized for these marketing efforts.
 - Mass marketing through print, tv, radio and billboards using high profile figures (governor, sports stars)
 - Local level outreach (churches, college campuses, beauty/barber shops grocery stores, libraries, extension centers, small businesses and job placement sites)

- 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 affordability and benefits and directs to resources

Additional Best Practices

Aside from the findings 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 different 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 benefits 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 significantly, thus causing unexpected outcomes – should be prepared for wide range.

Lesson #3: Barriers to coverage and access remain, even after expanding eligibility. Difficulty enrolling very low-income and keeping beneficiaries 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 significant administrative efforts to implement, including hiring more staff, transferring beneficiaries, and handling an increased volume of applications.

Lesson #6: Outreach around expansion may create a “welcome mat” effect, 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 beneficiaries.

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.

Further Reading Materials:

- [Becoming Healthy Louisiana: System-Assisted Medicaid Enrollment](#) – Kaiser Family Foundation (2016)
- Factors in Successful Medicaid Expansion Implementation – Louisiana Case Study – Maximus (2018) (available upon request)
- [Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials](#) – Medicare and Medicaid Research Review (CMS) (2013)
- [Medicaid Agencies Implement Innovative Outreach Strategies: Lessons from Kentucky and Virginia](#) – National Academy for State Health Policy (2020)
- Missouri Benefits Enrollment Transformation - Civilla and Missouri Department of Social Services Report (2020) (available upon request)
- [Moving the Needle on Health Insurance Coverage: Evaluation of the Cities Expanding Health Access for Children and Families Project](#) – Mathematica Policy Research (2016)
- [Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population](#) – Kaiser Family Foundation (2016)
- [Successful Medicaid Enrollment Strategies to Cover the Uninsured](#) – UnitedHealth Center for Health Reform and Modernization (2015)
- [Year Two of the ACA Coverage Expansions: On-the-Ground Experiences from Five States](#) – Kaiser Family Foundation (2016)