Connecticut Health Policy Project

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Connecticut Medicaid Expansion Outreach Report and Recommendations

Introduction

The intent of this report is to suggest strategies and avenues for outreach in order to register as many eligible Medicaid beneficiaries as possible for the January 2014 program expansion under the Affordable Care Act. This is a historic and unique opportunity for Connecticut to provide health coverage to 130,000 low income residents; it is incumbent upon policymakers to do everything possible to extend this opportunity to every eligible state resident. It is also important to note that the federal government will reimburse Connecticut for 100% of the costs of newly eligible Medicaid enrollees from 2014 though 2016, after which the rate of reimbursement declines slightly to 90% by 2010. Previously uninsured people will likely have unmet health care needs as they may not have received regular preventive care and screenings. Given the state's looming budget deficit, it is important to maximize federal reimbursement for those initial, higher health cost years.

The report draws on barriers to registration, lessons from past state health coverage outreach campaigns, recommendations for outreach effort targets, and highlights from other state models that have been successful in enrollment. The report closes with a set of web resources regarding health coverage outreach to supplement the body of the report. In addition to the listed web resources, information came from interviews with Lynne Ide (Universal Healthcare Foundation of CT), Sheldon Toubman (New Haven Legal Assistance Association), Deb Polun (Community Health Center Association of CT) and Ellen Andrews (CT Health Policy Project) during October 2012. While the report targets the anticipated expansion of Medicaid to 130,000 new enrollees in 2014 under the Affordable Care Act, many of the strategies and recommendations may apply to the state's new Health Insurance Exchange outreach as well.

Barriers to Registration

Like any new comprehensive legislation, the provisions of the Affordable Care Act can be confusing to consumers. Coupled with a health care system that is difficult to navigate, this fosters an environment in which people may be reluctant to register for health insurance, particularly when they are at low-risk for injury or chronic illness. Many low-income adults 19-64 years of age who will qualify for Medicaid, such as those without dependents, documented immigrant and mixed citizenship families, are unaware that they can benefit from the program's expansion. They may have limited or no experience with state services, or may be unsure about income eligibility levels, repayment policies, and where to sign up. Immigrants and non-English speakers face particular difficulties due to issues of transport, language barriers, fear of high costs and a confusing system for accessing services. Those who have used Medicaid, HUSKY and other state services in the past may have encountered a backlog in registration and negative experiences and/or stigma surrounding access to services, leading to a lack of trust in the

state and in DSS.

There are both myths and valid concerns among Connecticut's uninsured about health reform. For instance, many believe that all immigrants are excluded from public programs (untrue) and that they may have to pay back exchange subsidies if incomes rise (true). It is critical to survey uninsured state residents to collect all these myths and test messages to address them. Just conducting a comprehensive survey, especially if conducted through community-based groups, will help change perceptions and makes it clear that policymakers are listening and engaging people in a two-way conversation, building trust. Many uninsured residents do not know they are currently eligible – clear information on eligibility is key.

Trusted messages include:

- Peace of mind
- Affordability, no more debt
- Get a regular doctor
- Keep yourself healthy—you won't have to keep getting sick

Trusted messengers include:

- Doctors
- Nurses
- Clinics
- Social workers
- Clergy, communities of faith
- Friends, colleagues
- Employers

All of these barriers to enrollment present an opportunity to remedy the lack of knowledge surrounding eligibility, confusion surrounding access, and trust issues with the state. While none of this can be resolved overnight, key messages surrounding 1) affordability, 2) ease of use, 3) stability, which results from access to a regular doctor and peace of mind, as well as 4) empowerment to improve one's own or family health, in the short and long term, are important to convey during expansion efforts.

Lessons from Past Outreach Efforts (HUSKY)

Surveys show that people trust health information from medical professionals the most-- doctors, nurses, clinics settings-- followed by information from social workers, friends or colleagues, and employers. The following are six lessons from HUSKY outreach in recent years, based on CT Health Policy Project studies, key stakeholder interviews, and focus groups.

1. Make applications and program information ubiquitous.
Rising above the noise of information and overcoming myths and barriers will be daunting. It is not possible to overwhelm people with information. No one should wonder how to apply.

2. Large competitive grants are not a good idea.
Connecticut made a strategic mistake in HUSKY funding by releasing an RFP and giving large amounts of money to a small number of applicants. Many applicants who were not chosen decided that HUSKY outreach was no longer their responsibility. Because funding was substantial, the organizations that received it hired dedicated staff, deterring others in the same organization to work on outreach. The new staff had trouble knowing where to begin and existing networks were not properly utilized. A better option is to offer small grants to anyone with a good idea. This encourages organizations to add HUSKY outreach messages to the outreach work of army of community workers that make up Connecticut's safety net. Building on existing, trusted networks will be both more effective and more cost efficient. It also encourages testing innovative strategies and tactics, as no one's job is at stake. It is then critical to evaluate which ideas work, and share best practices with the entire army.

3. Talks to community groups are important, but outreach must go farther.
Many uninsured do not belong to organized community groups and/or are unable to attend talks due to work and other commitments. In the past, HUSKY outreach speakers have monopolized time on shared agendas at community meetings. Community groups were put off by the insistence to promote HUSKY at their meetings creating unnecessary and counterproductive tension. It is critical to find a way to collaborate with existing networks that is not a burden to essential partners and is respectful of their mission. Medicaid outreach should tap into existing networks in an appropriate way and go beyond this setting, considering strategies proposed in the sections that follow. It is far easier to integrate outreach into existing, successful community outreach efforts than to create a new structure from scratch. This is particularly true as the need for heightened HUSKY outreach will be short-lived centering on January 1st, 2014 when 130,000 new residents will qualify for the program. While it will take time to reach all newly eligible state residents, eventually new enrollment in the program will return to baseline levels.

4. Outreach must be linguistically and culturally appropriate.
In one HUSKY parent focus group for Spanish speakers, a mother explained that she had heard about HUSKY but didn't know what it was. Her employer had invited a speaker to her workplace and gave her time to attend the talk. But most employees at her worksite spoke only Spanish and the HUSKY outreach contractor sent a non-Spanish speaker. She and others sat through the talk and heard the word HUSKY several times, but understood nothing. (Ultimately, her family was eligible and we had a completed application by the end of the focus group). It may seem obvious, but outreach efforts need to cater to the circumstances of target groups and be respectful of cultural differences. This includes using translators at events, printing instructions and other information in multiple languages, and being mindful of how to engage with non-native English speakers, immigrants, and other minority communities in a way that is culturally appropriate and will resonate.

5. Word of mouth is the most reliable source of information.
Parties with no obvious conflict of interest will be the most trusted messengers, while those who are paid or get other monetary incentives to market Medicaid may be less effective, particularly if they are new to the field of outreach and have not built trusted networks. Trusted networks grow organically over time; it is not possible or advisable to build from scratch in the timeframe available.

6. Be careful reaching out to employers.
Wal-Mart faced adversity from unions, advocates and legislators in recruiting workers to register their families for HUSKY. The company was criticized for not providing employees adequate health benefits and instead relying on the state. Make sure the employees targeted are appropriate for the program.

7. Test everything; even well-meaning ideas fail.
A few great-sounding ideas in the HUSKY outreach efforts failed to launch, wasting time and money in the process. One example is of a K-Mart/Martha Stewart/HUSKY partnership, in which promotional gift bags were distributed at several Connecticut stores on subsequent Saturdays for 2-3 months. Thousands of bags with Martha Stewart Living gifts and HUSKY applications were handed out with only about a dozen returned applications in the entire process. Many gift bag recipients were observed taking out the gifts and throwing away the rest of the bag and its contents. Another failed idea was in the form of Hartford Courant inserts. A very early HUSKY B family survey found that some new enrollees had heard of the program by reading about it in the newspaper. This was surprising to advocates as newspaper readers tend to be higher income and have reached higher educational levels than the general population, contrary to uninsured populations. This was likely an artifact of sampling a very small number of early program enrollees. However, based on this result the state purchased advertising inserts in the Sunday Courant. Unfortunately only about eight tear off cards were returned; it is unknown if any of these eventually resulted in an enrollment. A better methodology for targeting precious media dollars would be to survey the opposite population for outreach leads – eligible people who had not yet enrolled. This is another example of how past HUSKY outreach efforts failed to merit the attention of target beneficiaries.

Recommendations

Medicaid outreach efforts will need to draw attention to the expansion both through existing networks and new arenas. The suggestions that follow incorporate ideas from the CT Health Policy Project, Kaiser Family Foundation, Robert Wood Johnson Foundation, leading state models, state consumer organizations, and other sources detailed at the end of the report.

1. Begin outreach with health service providers.
This includes current Medicaid providers, free clinics, community health centers, dental offices, hospitals - including clinics and emergency departments – DPH licensed health care workers, practice managers (refer to the Connecticut Medical Group Management Association), and professional societies. Target especially those who serve uninsured people.

2. Engage current HUSKY/Medicaid families.
Current enrollees may have newly eligible family members, friends and neighbors; this information should be readily accessible to DSS. Send announcements about the expansion to those in the system and kindly ask them to inform friends or acquaintances who may be eligible. Inform those who recently lost HUSKY/Medicaid due to income or lock out that they may be eligible again.

3. Connect with other public programs in state.

This may include unemployment, housing, legal aid, community action agencies, SNAP, energy assistance, schools, and the judicial and corrections systems.

4. Find trusted community messengers to spread the word.
Pay attention to people or organizations mentioned often (some listed below, "Suggested Places for Outreach") and spend time engaging with them, they may serve as a portal to many outreach opportunities. Connecticut's communities are unique. Trusted sources may vary significantly by community – in one neighborhood it may be a church and in another a school resource center.

5. Target life-changing transitions.
People are often moved to consider health insurance at important life events and transitions such as marriage, the birth of a child, moving, a death in the family, a new job, or unemployment. These are teachable moments when people think about responsibility and risk – prime opportunities to emphasize the need for health coverage. These events suggest outreach vehicles such as providing information with marriage licenses, new baby hospital packets, at rental and moving businesses, new employee orientations, in COBRA packets, with unemployment applications, and when a death is recorded.

6. Make the application user-friendly and readily available.
- Enable online access: many low-income people do have internet access, whether at a public library, school or through a smart-phone. The more power the consumer has the better, including and especially through easy access to information.
- Shorten the length of the application and simplify language. Include multiple language options.
- Offer a registration help line with Spanish-speaking operators and extended hours. This could work in tandem with the Exchange help line.
- Clearly inform applicants of the next steps taken by DSS and required of the applicant, with a relevant timeline.

7. Consider using online social media outlets.
Facebook, MySpace, Twitter and other sites may be a way to reach young adults in particular.

8. *Thank people.*
It is critical to demonstrate appreciation to outreach workers and their organizations that help enroll Medicaid members. The state should find meaningful ways to recognize groups or individuals that excel in outreach. Options include features on websites and newsletters, legislative citations and ceremony, highlighting at the large outreach conference, earned media focus, or a visit by high level policymakers to their site.

Suggested Places for Outreach

1. State Level
- Large employers, including state and municipalities, to send those over 26 aging off existing parent's coverage
    - E.g. 1,700 young adults age out of state employee health plan coverage every year

- Community and state colleges and technical schools
- Secretary of the State, to target small businesses
- DMV in all communications
- State parks – many low income residents frequent parks for vacations and leisure
- Ct.gov, CT-N
- Elected officials, including federal, state, local; through community meetings and mailings – they know how to reach people in their communities, it is how they got their job
- Exchange navigators, who should be able to enroll others for Medicaid or appropriate insurance program as part of their role
- Unemployment office
- Judicial department
- Corrections

2. Community Level

- Libraries
- Community events and fairs, including local health department and job fairs
- Community organization newsletters, emails
- School health centers and nurses offices
- School family resource centers
- First week of school take-home packets, report card mailings and evenings

3. Independent Entities

- Churches (particularly in low-income neighborhoods), through interfaith coalitions, bulletins
- Chambers of commerce
- DPH licensed small businesses such as restaurants, hairdressers, barbers, daycare facilities
- Labor unions
- Insurance brokers
- Low-wage employers
- Food pantries
- Homeless shelters
- Arts councils

4. Other Avenues

(may require fee or incentive for marketing)

- Thrift stores
- Casinos
- Gas station ads
- Public transit (e.g. bus) ads
- Movie theatre ads (may even cater to specific demographic such as young males, based on movie type)
- Earned media – talk radio, online news, free newspapers
- Latino radio stations (ads)

- Lottery ticket winners
- Campgrounds
- Life-changing moments which already involve paperwork: marriage license application, house purchase, birth registration (hospital), drafting will (attorney), bank loan

5. Specific Agencies

- Meriden Children First
- Bridgeport Child Advocacy Coalition
- Healthy Start grantees
- CT Parent Power
- Children First Communities
- CT Early Childhood Alliance
- CT Association for Human Services
- Citizens for Economic Opportunity
- Health Care 4 Every 1
- CT Center for a New Economy
- CSEA, SEIU, Unite Here
- Community Health Center Association of Connecticut, Medicaid Outreach Workers

Lessons Learned from State Models

Massachusetts has the most active and progressive state-run health insurance exchange to date. A variety of literature has been published on lessons learned from its state exchange and Medicaid outreach since its inception. With a focus on the successes of the Massachusetts model and consideration of lessons learned in California and Utah, this final section of the report will incorporate lessons into recommendations that apply to Connecticut.

1. Make use of a "top-down, bottom up" approach.[i]

Since the 2006 health reforms went into effect, outreach in Massachusetts has been comprehensive and continuous. Early outreach included mailings sent to new residents through the state realtors' association databases as well as mailings to all small businesses and taxpayers through the Department of Revenue. Community outreach was facilitated by a large community organization rather than the state, however this could be difficult to apply in Connecticut as we do not have an organization akin to Massachusetts's Health Care for All.

Other Massachusetts outreach efforts included large advertisements and wide distribution of brochures, as well as paid advertising on television, radio and in newspapers. The state held thirty events in twenty targeted communities to educate and enroll, with incentives like raffles to get people to attend. The Mass Health Connector also formed a partnership with the Boston Red Sox to market coverage to younger residents, particularly young men.[ii] In California, the state exchange has enrolled eligible residents through less conventional partnerships with large retailers, radio and television personalities and local sports teams. They have also made working with colleges and universities a priority and have

reached new beneficiaries through student health clinics, parent/student orientation, schools, social media and alumni associations.[iii]

2. Enrollment strategy should enable presumptive eligibility.
Massachusetts allowed immediate Medicaid coverage through presumptive eligibility. The state worked with its own, hospital, and community health center databases to determine who would qualify based on income and relevant information.[iv] California has also set up an auto-enrollment system for its Low Income Health Program population based on 2014 eligibility.[v] Connecticut has used this successfully in the past.

3. Small grants are key.
For the past several years, Massachusetts has awarded around 50 mini-grants of $5,000-20,000 annually to enable community organizations to facilitate Medicaid registration and renewal. Grantees have targeted geographic areas, ethnic or language groups as well as known service populations for enrollment.[vi] Connecticut should also invite non-grantee community organizations and other stakeholders to attend best practice meetings. A grant should not be required to join the effort.

4. Make sure technology employed is user-friendly.
Massachusetts developed an online "virtual gateway" system which has enabled providers to quickly and easily assist uninsured, low-income individuals apply for Medicaid.[vii] The state's Health Connector insurance exchange website has also received accolades for ease of use and breadth of information made accessible to state consumers. On the other hand, Utah has encountered shortcomings in launching its online insurance exchange site, with problems ranging from login failure to miscalculation of premiums.[viii] Connecticut should be mindful of how it develops its website, particularly in terms of ease of access and availability of succinct, relevant information.

5. Convene regular meetings to share best practices.
MassHealth conducts regional monthly meetings with its grantees to highlight best practices and challenges in the field and update grantees on changes in policy. This provides an opportunity for those involved in outreach to network with each other and share their successes, failures and strategies for improvement in a supportive environment. Connecticut could adopt this strategy in its outreach efforts and even allow communication with top policymakers at meetings, which may encourage accountability and increase motivation among outreach workers. In addition to its monthly regional meetings, Massachusetts holds occasional (bi-annual/annual) conference style meetings for all involved in outreach at a hotel or other upmarket venue, with inspirational speakers, lunch and poster-table displays created by attendees as a way to showcase efforts, express gratitude to involved parties and incentivize the program. In addition to breakout sessions relevant to outreach and program updates, the conferences also include skill sessions (e.g. media training) of value to community organizations and ample opportunities for informal networking, making it easier for Executive Directors to justify staff time to attend.

In addition to promoting best practice meetings among outreach workers, Connecticut could create an inclusive advocates advisory committee. This would provide a constructive way to share advocates'

perspectives with DSS and other governing bodies and to engage lead organizers in promoting outreach.

Follow-up

A critical component of any outreach effort is its ability to monitor, evaluate, and report both successes and ideas that didn't work. Adjustments should be made when problems arise, and mechanisms for training and knowledge sharing by outreach workers and other key messengers should be established. Finally, recognizing individuals or groups who excel in outreach and thanking people in meaningful ways for their efforts will promote retention and loyalty to the mission.

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Additional Resources

HUSKY Parent Focus Groups (CT Health Policy Project), 10/1999
http://www.cthealthpolicy.org/husky/focus/default.htm
Informing CHIP and Medicaid Outreach, National Survey (CMS), 11/2011
http://www.insurekidsnow.gov/professionals/CHIP-Medicaid-Survey-Topline.pdf
CT Consumer/Small Business Input into Exchange Outreach (CT Health Policy Project), 3/2012
http://www.cthealthpolicy.org/briefs/issue_brief_60.pdf
Effective Education, Outreach, and Enrollment Approaches for Populations Newly Eligible for Health Coverage (RWJF), 3/2012
http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/03/resources-from-the-massachusetts-implementation-experience/effective-education--outreach--and-enrollment-approaches-for-pop.html
Performing Outreach with Limited Resources (RWJF), 9/2009
http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/09/performing-outreach-with-limited-resources.html
Key Issues to Consider for Health Reform Outreach (KFF), 2/2012
http://www.kff.org/healthreform/8280.cfm
Connecting Eligible Immigrant Families to Health Coverage: Lessons from Outreach Workers (KFF), 10/2011
http://www.kff.org/medicaid/8249.cfm
Implementing a Successful Public Education and Marketing Campaign to Promote State Health Insurance Exchanges (MA), 5/2011
https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/MassachusettsExperienceMarketingToolkit.pdf (MA: RWJF, BCBSF et al.)
Effective Education, Outreach and Enrollment Approaches for Populations Newly Eligible for Health Coverage (MA: RWJF, BCBSF et al.), 3/2012

https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/LessonsForNROutreachAndEnrollmentToolkit.pdf
Massachusetts and Utah Health Insurance Exchanges: Lessons Learned (Georgetown U.), 3/2011
https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2011/Week%2520Beginning%2520April%252003/MassAndUtahExchangesLessonsLearned.pdf
MA Health Reform: A Five Year Progress Report (Blue Cross Blue Shield Foundation), 11/2011
https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/BlueCrossFoundation5YearRpt.pdf
Achieving Health Care Coverage Success in 2014 and Beyond: Stakeholder Input on Strategies for Marketing, Eligibility, Enrollment and Retention (CA Health Benefit Exchange), 3/2012
http://www.healthexchange.ca.gov/StakeHolders/Documents/AchievingHealthCareCoverageSuccessin2014andBeyond.pdf

Note: Recommendations are the opinions of the authors. They do not all necessarily reflect the interests and opinions of all interviewed.

[i] Georgetown University, 3/2011
[ii] Georgetown University, 3/2011
[iii] CA Health Benefit Exchange, 3/2012
[iv] Blue Cross Blue Shield Foundation, 11/2011
[v] CA Health Benefit Exchange, 3/2012
[vi] Georgetown University, 3/2011
[vii] Blue Cross Blue Shield Foundation, 11/2011
[viii] Georgetown University, 3/2011