STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 2 3 2009

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2009 Joint Chairmen's Report (P. 100) – Report on Barriers to Enrollment and Outstation Eligibility Workers

Dear Chairmen Currie and Conway:

In keeping with the requirements of the 2009 Joint Chairmen's Report (p. 100), the Department is submitting the attached report on the options for reducing enrollment barriers at the community level, including the use of outstation eligibility workers. The report was originally due on November 1, 2009, but the Department was granted an extension to January 1, 2010.

If you have questions or need more information on this subject, please contact Shawn Cain, Assistant Director of Governmental Affairs, at (410) 767-6509.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
John Folkemer
Tricia Roddy
Shawn Cain

Barriers to Enrollment at the Community Level
December 2009

Introduction

The 2009 Joint Chairmen's Report directed the Department of Health and Mental Hygiene (the Department) to seek input from stakeholders, because of their experience working with Medicaid enrollees and their ability to contribute constructive solutions, on how best to reduce enrollment barriers to the State's Medicaid and Maryland Children's Health Program (MCHP). Particularly, the committees are interested in how outstationed eligibility workers may reduce enrollment barriers facing pregnant women and children. The Department welcomes stakeholder comments and is committed to reducing enrollment barriers for all Medicaid-eligible individuals.

This report describes the steps taken by the Department to reduce enrollment barriers. It begins by discussing the acquisition and planned use of grant funds through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Grant. Next, it provides a summary of stakeholder discussions concerning potential enrollment barriers and strategies for reducing them.

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CHIPRA Grant to Reduce Enrollment Barriers for Children

Reducing enrollment barriers remains a top priority of the Department, notwithstanding current economic conditions. To offset State budget reductions, the Department continues to examine third-party funding sources, such as grant opportunities. The Department was one of 69 grantees from 41 states to recently receive an Outreach and Enrollment Grant from the Centers for Medicare and Medicaid Services (CMS). The Department's two-year grant totals $988,177

Authorized by the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA), the grant is designed to help grantees increase outreach and retention for eligible but hard to reach children. CMS awarded a total of $40 million of the available $80 million in grants, meaning future opportunities exist for additional funding.

The Department plans to use these funds to reduce enrollment barriers by implementing a statewide, web-based application, One-e-App, for Medicaid and MCHP services. This application will be easy to use and should simplify and reduce the time for the enrollment process by allowing eligible individuals to apply either at outreach centers, such as hospitals and federally qualified health centers (FQHCs), or from any internet terminal.

Successfully implementing a statewide, web-based enrollment application requires that the Department devote a significant amount of scarce staff resources. Prioritizing projects is of critical importance during this period of severe demands on staff time – and, in the short term, this means focusing on the grant.

The next section describes additional stakeholder suggestions for reducing enrollment barriers. Although these suggestions include viable alternatives, many require new funding. The Department remains committed to reducing enrollment barriers, but it understands the fiscal sensitivity to funding additional suggestions at this time.

Stakeholder Focus: Administration, Outreach, and Eligibility

The Department met with stakeholders to identify and provide solutions for barriers to enrollment. For a complete list of suggestions and stakeholders, see Appendix 1 and 2, respectively. Generally, these barriers fell into three categories: administration, direct outreach activities, and eligibility policy.

Administration

Stakeholders proposed a number of solutions to improve the eligibility process. Suggestions ranged from redesigning the application to increasing staffing levels to making changes to our eligibility systems.

Stakeholders strongly support our efforts to simplify the enrollment process, and they praise how the web-based application process attempts to do so. And although many of the stakeholder suggestions may be difficult to implement at this time because of funding concerns, the stakeholders had one excellent suggestion that the Department may implement easily – by simply reaching out to stakeholders to ensure the efficacy of the web-based system, the Department may quickly and cost effectively improve the planning process. Other examples that the Department will pursue include redesigning and simplifying the application and following up with the Department of Human Resources on the issue of the time of day when maintenance occurs on the Client Automated Resource and Eligibility System (CARES).

Unfortunately, given the budgetary constraints facing our State, the Department must delay pursuing many of the other suggestions. We would welcome the opportunity to increase staffing levels – and note that improving staffing levels was suggested also by the Budget Committees – but understand the fiscal realities under which we are laboring. That said, the JCR language specifically requires that the Department comment on its compliance with federal law to provide outstationed workers at locations other than local departments of social services. Under federal law, states must establish (1) outstation locations at each disproportionate share hospital (DSH) and each FQHC; ***or*** (2) other outstation locations, which include at least some, disproportionate share hospitals and federally qualified health centers as specified under an alternative state plan that is submitted to and approved by CMS. Maryland complies with (2). Maryland provides outstationed workers to most DSH hospitals, some FQHCs, and all local health departments.

The Department agrees that providing more outstationed workers may help reduce barriers to eligibility. But funding sources first must be identified. Only then would it be appropriate to determine how best to allocate such funds. For example, Maryland could consider a performance payment plan that adjusts funding levels based on the number of applications processed by the outstationed workers.

Direct Outreach Activities

Stakeholders made a number of suggestions to expand direct outreach initiatives, such as through the use of flyers and public service announcements. Recently enacted, but not yet implemented, State law requires the Department to send eligibility and enrollment information to families whose children participate in the National School Lunch Program in Baltimore City Schools. In addition, the Kids First Act requires that the State use State tax information to identify and reach out to uninsured children. Families whose incomes fall below the MCHP income threshold will receive applications and enrollment information.

Budgetary constraints prevent the Department from further pursuing additional direct outreach activities at this time, however. Until alternative sources of funding are identified, the Department plans to continue partnering with non-profits focusing on these goals, such as the Maryland Citizens' Health Initiative. (Maryland Citizens' Health Initiative has received over $400,000 in grant money that it is using now on direct outreach activities.)

Eligibility Policy

The stakeholders suggested that the Department implement one key policy change – 12-months of continuous eligibility for children. Continuous eligibility would guarantee coverage of children for 12 months, regardless of any eligibility-related changes.

Until 2004 Maryland guaranteed eligibility for all HealthChoice enrollees for 6 months.[1] However, the Department discontinued the policy for cost containment reasons. While the Department believes that continuous eligibility would improve access to health care coverage for children, such improvement comes at a quantifiable cost. Based on available data and certain assumptions, the Department estimates that 12-months of continuous eligibility for children will cost roughly $58 million (total funds).

CMS is offering states bonus payments in order to encourage the adoption of enrollment simplification policies for children, such as continuous eligibility. The monies are authorized through CHIPRA. To qualify, states must implement five of eight specified initiatives aimed at simplifying enrollment and renewal procedures as well as achieve increased enrollment level targets. Maryland would have to implement two new initiatives in order to qualify.

The enrollment level target methodology is based on the State's 2007 enrollment levels. Over the last 18 months, Maryland has experienced tremendous growth simply due to the poor state of the economy, expanded coverage to parents, and outreach initiatives, such as the Kids First Act. Since July 2008, Maryland has covered more than 50,000 additional children. This means that, although Maryland meets the enrollment threshold criteria for a bonus payment, the State is prohibited from receiving any such payments without first implementing two additional enrollment simplification and retention policies.

If the Department implements two additional policies to further simplify enrollment, more children will become eligible for the program. Increased enrollment levels directly impact

[1] Federal rules permit12-months of continuous eligibility only for children. Other populations served under an 1115 Research and Demonstration Waiver may receive up to 6-months of continuous eligibility.

the Department's budget, and the bonus payments offered by CMS are not enough to cover the additional costs associated with the enrollment. (See Appendix 3 for more detail on CHIPRA Bonus.) Although there would be some savings from not having to re-enroll children who later become eligible, data suggest that such savings would not offset the increased service costs.

Conclusion

The Department is committed to reducing enrollment barriers and the laudable goal of covering all children. With the increased funding provided by the CHIPRA Outreach Grant, the Department will be able to reduce enrollment barriers for Medicaid- and MCHP-eligible individuals, including children and pregnant women, by implementing a state-wide application system. The web-based system will simplify the application and enrollment process, thereby reducing many of the enrollment barriers articulated by stakeholders. Because of current fiscal constraints, however, the Department must postpone implementing many of the other suggestions until alternative sources of funding are identified. An analysis of relevant data suggests that CHIPRA Bonus Payments (offered to encourage the adoption of continuous eligibility policies) would not offset the increased costs associated with services for new enrollees.

Moving forward, the Department will continue to reduce enrollment barriers by working closely with stakeholders and identifying alternative sources of funding. We will also focus our attention on (1) implementing the CHIPRA Grant; (2) redesigning the application for families and children; (3) working with Maryland Citizens' Health Initiative and other non-profits on direct outreach initiatives; and (4) following up with the Department of Human Resources on the issue of whether or not eligibility system maintenance can occur after normal work hours.

Appendix 1
Stakeholder Feedback

Category	Problem	Solution
Outreach	Lack of understanding about Medicaid program eligibility, plan coverage, Medicaid card usage, and the client's responsibility to maintain and update their eligibility.	1. Produce a series of Public Service Announcements that can be played in the local health department lobbies and local television and radio stations in multiple languages to educate, empower, and inform clients about Maryland Medical Assistance. Pay special attention to low-income and minority residents. 2. Outreach via the school system, especially the 366 Title I schools. Notify parents well in advance of re-determination period through school system. Have staff (from DHMH, DHR or key Medicaid providers) stationed at schools on a scheduled basis to assist with re-determination process. 3. Send flyers to School nurses, homeless shelters, hospital emergency rooms, the State Board of Dentistry, and the MIA. All Maryland Schools of Social Work and Schools of Nursing should receive flyers. Focus groups of low-income persons with limited formal education should be used to test the readability and the level of attention elicited by various versions of the content and format. There should be Braille versions as well. Informal kinship care relatives might pick up the material at Senior Centers, as well as from those pupil personnel officials who handle new admissions and student transfers. 4. Using the National School Lunch Program and income tax reports to identify individuals potentially eligible for Medicaid and MCHP is a good idea. The Department should explore other avenues. 5. Increase number of bi-lingual outreach workers including creating incentives to attract more bi-lingual outreach workers or offering language courses to staff who wish to become bi-lingual. 6. Build upon present outreach efforts to eliminate barriers and increase enrollment. These could include: • Analysis of data from implementation of the Kids First Act to determine its present efficacy and future potential. • Analysis of data from the Baltimore National School Lunch Program initiative to determine efficacy of present design and for potential for expansion statewide. • Build upon present media campaign and continue expansion of the 211 line.
Administrative	One-E-App needs to implemented properly	Planning efforts include: • A core mission to enroll every eligible child in the state and to do so with a program that is sustainable in the long-term; • Identification at the outset of both short- and long-term goals to ensure that costly patches will not be necessary within the next 5-10 years. • Cooperation across all relevant departments to increase both identification and enrollment. • Analysis of efforts in other states to facilitate design of the most effective and comprehensive systems. • Input from a variety of stakeholders to ensure the program's efficacy when it is put into use, including: DHMH staff at different levels; advocacy groups, as well as Medicaid and MCHP clients.
Administrative	Application processing is different across Local Health Departments and others involved in the process.	1. Develop standards and best practice process for application processing. 2. Ensure that all Local Health Departments, and others involved in processing of applications are applying the same standards and processes.

Category	Problem	Solution
Administrative	Antiquated IT system makes determination and eligibility challenging.	1. Use One-e-App software to improve the application process, paying particular attention to interoperability between other benefit systems to ensure an appropriate interface and single-point of entry 2. While it may make sense to start with health (MCHP and PAC), the system must be designed in such a way as to accommodate other programs such as food stamps, WIC, the National School Lunch Program, energy assistance, etc. in the future. The system should be able to accommodate or interface with all State agency income-eligible benefits programs. 3. Local health departments must have the capability through Health-e-Link or otherwise to share data with DHMH as well as other agencies. Currently, local health departments cannot enter new addresses for clients into the DHMH data base. 4. All computer systems dealing with eligibility and enrollment should not be shut down during the day for maintenance. Currently, some systems are. Instead, maintenance should occur during non-business hours.
Administrative	The current application is very intimidating and in some cases unclear.	1. Use images to improve understanding of directions on how to fill out the application. 2. Add more slots for names on the first page of the application. 3. Better explain the gray pages of the application and signatures required on the final signature page.
Administrative	Redundant application processes for healthcare and social service benefits.	Public assistance application integration via electronically shared household eligibility documents/databases to confirm multiple benefits status and eligibility disposition in the state of Maryland and other states, especially Maryland border states and the District of Columbia.
Administrative	Even with a robust technological interface system such as the one being designed with the CHIPRA Grant funds, Application Assistors will be needed to assist individuals applying in their communities.	The Department and local health departments should partner with community organizations to recruit and train assistors. Community partnerships around application assistance will decrease the burden placed on state and local eligibility workers.
Administration	Enrollment systems may not have the capacity to accommodate surges in applications. This occurs when increased outreach efforts that produce surges in applications are not accompanied by additional funding for staff or an automated system for screening applicants.	1. Increased outreach efforts must be accompanied by additional funding for eligibility staff, or possibly an automated eligibility system for screening. 2. Commit to a level of funding, workforce realignment, education/training and other elements required to ensure the sustainability of the Health-E-Kids program over the long-term. IT systems alone are not the "silver bullet." The state's present economic challenges may preclude increased staffing in the short-term. Therefore, DHMH will need to work with stakeholders at all levels to ensure full operability of the systems. At the same time, the Department will need to prepare for the long-term solutions.
Administrative	A significant enrollment barrier for applicants is providing citizenship and identity documents per DRA requirements for an otherwise declaratory application.	Automated citizenship and identity clearance confirmation via integrated county, state, and federal databases would reduce the greatest enrollment barrier for Medicaid eligible populations who typically lack the funds and resources to obtain all necessary verification documents and are denied benefits that they are otherwise entitled. An estimated 75-80% of our denied applications are due to lack of verification documents.

Category	Problem	Solution
Eligibility Policy	Maryland's multiple MA eligibility categories are arcane. It is hard for policy wonks to keep them straight—much less potential applicants or 211 call recipients.	1. Wherever possible, the State should simplify or eliminate multiple categories and rules. In addition rules must be applied consistently across jurisdictions. Simplification should start with making everyone continuously eligible for 12 months. 2. Streamline, internally, the eligibility determination process between DHR and DHMH; having applications go between two agencies is time consuming, costly and creates opportunities for application loss and delay. Have all applications go through Health Department. 3. Pilot 12-month eligibility and evaluate the dollars saved in lost continuity of care and re-establishment against costs associated with persons no longer eligible getting care. 4. Enhance the re-establishment process by paying key Medicaid providers such as FQHCs to do the re-establishment/determination process. 5. Reduce documentation requirements; have outreach assist with obtaining documents and/or provide interim coverage while documents are being obtained. 6. To expedite the eligibility and enrollment process consider ways to use One-E-App as a tool for presumptive eligibility. 7. DHMH should continue to pursue these: • Pass legislation enabling presumptive eligibility of children based on a family's declared income • Pass legislation enabling 12-month continuous eligibility • Pass legislation funding state of the art information systems for all health and social services, maximizing federal matches to do so. This will enable sharing of data across agencies, gathering data from primary data sources, data matches, storage and updating of data etc. • Continue to simplify application, enrollment, and renewal procedures for families (dependent on up to date information systems) • Support biennial (every 2 years) renewal so as to reduce administrative burdens and insure eligible children of continuous coverage (New York State is considering this) • Support auto-renewal of kids whose family income remains at or below 150% of poverty for several preceding years (presumptive eligibility) • Support auto-enrollment of all uninsured newborns (Connecticut is already doing this)

Appendix 2
Stakeholders Who Provided Feedback

Name	Organization
Salliann Alborn	Community Health Integrated Partnership & Maryland Community Health Systems
Leigh Stevenson Cobb	Advocates for Children & Youth
Suzanne Gilbert	Maryland Citizens' Health Initiative
Senator Delores G. Kelley	Maryland Medicaid Advisory Committee
Leni Preston	Maryland Women's Coalition for Health Care Reform
Ulder J. Tillman, MD	Maryland Medicaid Advisory Committee Montgomery County Department of Health and Human Services

Appendix 3

CHIPRA Bonus Payments

CHIPRA provides performance bonuses for states that: 1) implement five of eight specified enrollment and retention provisions; and 2) increase child enrollment to specified levels beyond the state's enrollment targets.

Enrollment and Retention Provisions

Of the eight specified enrollment and retention provisions, Maryland has implemented three. They are the first three highlighted below.

1) ***Eliminate the asset test for children****;*
2) ***Eliminate in-person interview requirements at application and renewal****;*
3) ***Use joint applications and supplemental forms and the same application and renewal verification process for the two programs****;*
4) Adopt 12-month continuous eligibility for all children;
5) Allow for administrative or paperless verification at renewal through the use of pre-populated forms or ex parte determinations (when a state uses information available to it through other databases to verify ongoing eligibility);
6) Exercise the option to use presumptive eligibility when evaluating children's eligibility for coverage;
7) Exercise the new option in the law to use Express Lane; and
8) Exercise the new options in the law in regard to premium assistance.

Enrollment Targets

In addition to implementing five of the eight enrollment and retention provisions, Maryland must meet child enrollment targets. The child enrollment targets are associated with two tiers of bonus payments. The federal government will pay: 15 percent of the State's cost for each child above the target for the first 10 percent; and 62.5 percent of the costs for every child enrolled beyond that first 10 percent level.

The enrollment level target methodology is based on the State's 2007 enrollment levels. Over the last 18 months, Maryland has experienced tremendous growth simply due to the poor state of the economy, expanded coverage to parents, and outreach initiatives, such as the Kids First Act that uses tax payer information to identify eligible individuals for enrollment. This means that, although Maryland meets the enrollment threshold criteria for a bonus payment, the State is prohibited from receiving any such payments without first implementing two additional enrollment and retention provisions.

Estimated Cost of Implementing Two Additional Enrollment and Retention Provisions

Maryland would need to implement two additional enrollment and retention policies. The provisions and estimated implementation costs are described below.

Performance Measures	Description	Estimated FY 10 State General Fund Cost –Maryland's Normal Federal Matching Rate and the enhanced rate under ARRA (ends December 31, 2010)
1. 12-Months Continuous Eligibility for Children	Guarantees a full 12 months of coverage for children enrolled in Medicaid and CHIP, regardless of changes in their financial circumstances	$58 Million (TF) $27 Million (GF) w/out ARRA $22 Million (GF) w ARRA Note – These cost assumptions do not include any system costs associated with making changes to CARES.
2. Allow for administrative renewals	Requires enrollees to only follow up during renewals if their circumstances have changed. For instance, the State would send a pre-printed form with the most current information available to the State and require the parent or caretaker to report any changes. If the parent or caretaker does not report any changes, eligibility is automatically renewed and coverage continues.	It is difficult to estimate the impact of how many families would provide any updates on status. The Department estimates, however, the cost estimate to be higher than continuous eligibility or presumptive eligibility
3. Exercise the option to use presumptive eligibility when evaluating children's eligibility for coverage	Allows children to get medical care right away while the final eligibility decision is pending. Typically, children are made presumptively eligible for 90 days. During this time, the families are required to complete an application and be determined eligible in order to stay on the program. Qualified entities are certified by the State agency to make presumptive eligibility determinations. Maryland would need to develop a system of approved providers to make presumptive determinations. This obviously brings with it administrative costs, particularly at start-up.	$27 to $45 Million (TF) $13 to $22 Million (GF) - w/out ARRA $10 to $17 Million (GF) – w ARRA Note – These cost assumptions do not include any additional administrative costs associated with developing a system of qualified entities to make presumptive eligibility determinations.
4. Exercise the new option in the law to use Express Lane	Allows states to use eligibility for other public programs to determine that a child satisfies one or more components of eligibility for Medicaid or CHIP	Approximately 150,000 families with incomes below 300% FPL indicated dependents without health insurance on their 2008 income tax form. Many of these children may already be enrolled, but an express lane process will significantly increase enrollment.
5. Exercise the new options in the law in regard to premium assistance	Provide subsidies to families who are enrolled in qualified group health and employer-sponsored coverage	During the 2003 legislative session, the General Assembly voted to discontinue Maryland's employer sponsored insurance premium assistance program.

The CHIPRA bonus payments offered by CMS are not enough to cover the additional state costs -- $32 million to $39 million -- associated with implementing two additional enrollment and retention provisions, *i.e.*, providing 12-months continuous eligibility for children ($22 million) and using presumptive eligibility when evaluating children's eligibility ($10 million to $17 million).[2] Even with the increased bonus payments, Maryland would incur $17 million to $24 million in additional State costs. These costs assume that the enhanced match from the American Recovery and Reinvestment Act of 2009 (ARRA) continues to June 30, 2011. Currently the enhanced match is scheduled to end January 1, 2011. Without the enhanced ARRA monies, the State cost would be between $20 million to $29 million.[3]

[2] Costs do not include any administrative costs associated with implementing the policy changes.
[3] Costs are offset by the CHIPRA bonus payments.