

Eligible but Uninsured: Challenges to Getting and Keeping MassHealth

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Introduction

Governor Romney's "Commonwealth Care" health care reform proposal estimates that 106,000 people in Massachusetts are eligible for MassHealth but instead are uninsured. Bringing these people into MassHealth is a major component of the Governor's plan and would reduce the number of uninsured in the Commonwealth by nearly a quarter, from 460,000¹ to 354,000.

Health care reform is once again moving toward the top of the Massachusetts public policy agenda, exemplified by the Governor's proposal, Senate President Travaglini's announced desire to halve the number of uninsured in two years, comprehensive reform legislation filed by Senator Moore and Representative Blumer, Health Care for All's Comprehensive Health Reform Campaign, and the Blue Cross Blue Shield of Massachusetts Foundation's Roadmap to Coverage initiative. A constitutional amendment to guarantee residents of the Commonwealth access to adequate and affordable health coverage is pending, and there is likely to be further activity as the new legislative session gets underway.

One logical component of all of these efforts to expand coverage and access is to maximize the enrollment of Massachusetts residents who are already eligible for existing programs. This paper explores some of the reasons eligible individuals may not be enrolled in MassHealth and suggests some approaches to identifying and enrolling them.

¹ Massachusetts Division of Health Care Finance and Policy. November 2004. *Health Insurance Status of Massachusetts Residents, Fourth Edition*.

Background

Who Are the MassHealth Eligible Uninsured?

Compared to most other states, Massachusetts has a relatively low overall percentage of residents without insurance (10% in Massachusetts compared to 16% nationally).² The rate among Massachusetts children is 7 percent (compared with 12% for the US), and it is 14 percent for adults age 19-64 (compared with 20% for the US). Massachusetts also has a relatively high rate of participation in its Medicaid program, with at least 90 percent of eligible people enrolled.³ By comparison, a recent national study found that, of all adults eligible for public programs, just over half (54%) were enrolled.⁴ The high level of participation in Massachusetts is a testament to successful enrollment and retention efforts in the past, but also indicates that the challenge to enroll the remaining eligible people may be substantial and will require a determined and very targeted effort.

While Massachusetts has relatively high rates of insurance coverage and Medicaid participation, it has also seen, over the past several years, an increase in the number of uninsured residents. The number of uninsured Massachusetts residents increased by 95,000 from 2000 to 2004. The number of MassHealth recipients fell by over 80,000 in 2002 and 2003, but enrollment has grown steadily in the past year. As of the end of January 2005, enrollment was about 20,000 below the peak of 996,000 reached in August 2002.⁵ The recent growth in enrollment may result in part from the October 2004 change in procedure that requires that the MassHealth application be used to apply for the Uncompensated Care Pool. Because the same application is now used for both programs, some previously uninsured people may have been shifted onto MassHealth. If MassHealth enrollment were expanded to include just a portion of the estimated 106,000 eligible people, the program could grow to over one million members, an all-time high.

² This estimate differs from that cited in the Massachusetts Division of Health Care Finance and Policy Report of November 2004, which states that “the percent of uninsured people in Massachusetts increased to 7.4% of the population in 2004 from 6.7% in 2002.” For the purposes of national comparison we are using the 10% figure from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured, which based its estimates on pooled March 2003 and 2004 Current Population Surveys.

³ The current enrollment of 974,000 is about 90 percent of what the total would be if the estimated 106,000 eligible unenrolled were added. To the extent that some of the 106,000 have enrolled in recent months, the percentage would be higher.

⁴ A. Davidoff et al., *Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment*. Kaiser Commission on Medicaid and the Uninsured, April 2004. This same study found that, of the 13 individual states studied, Massachusetts’s participation rate was the highest by far. The overall national participation rate, including children, is probably somewhat higher than 54 percent since eligible children are more likely than adults to enroll.

⁵ Source: Office of Medicaid

According to the Massachusetts Division of Health Care Finance and Policy, the uninsured people who may be eligible for MassHealth are estimated to be eligible as follows:

Eligibility Criteria	Estimated Number of Eligible People
Children at or below 200% of poverty level ⁶	32,000
Children between 200%-300% of poverty level	10,000
Parents of children at or below 133% of poverty level	26,000
Disabled adults at or below 400% of poverty level	5,000
Unemployed adults at or below 100% of poverty level	33,000
Total	106,000
% of Total who are adults	61%
% of Total who are children	39%

Source: Division of Health Care Finance and Policy

The data used in this estimate were collected by the state between March and August 2004. There are several reasons the estimate may overstate the number of potentially eligible but unenrolled people. First, MassHealth enrollment has grown by about 24,000 members since August and 38,000 since March (though not all of these new enrollees were necessarily uninsured prior to their enrollment). Second, the 10,000 children between 200 and 300 percent of the poverty level are not currently eligible for MassHealth, but would be if eligibility were expanded as directed in a section of the FY 2005 budget.⁷ The estimate also does not take immigration status into account; some non-citizens are not eligible for any MassHealth program. In short, the goal of reducing the uninsured ranks by nearly a quarter by moving those uninsured people onto MassHealth should be viewed as the outer bound of possibility.

The Massachusetts Division of Health Care Finance and Policy's November 2004 report on health insurance status states that low-income Massachusetts residents (household incomes below 200% of the federal poverty level) were more likely to be uninsured in 2004 than in 2002. The report further states that "the increase in the Massachusetts uninsured rate is nearly all attributable to an increase in the number of uninsured non-elderly adults."⁸ This, taken with the information that 61% of the estimated number of MassHealth eligible uninsured people are adults, indicates that a program to increase enrollment should focus on adults at least as much as on children.

⁶ Poverty level income was \$18,850 for a family of four in 2004.

⁷ Acts of 2004, Chapter 149, Section 266. EOHHS is currently working with the federal government to get approval for this eligibility expansion.

⁸ Massachusetts Division of Health Care Finance and Policy. November 2004. *Health Insurance Status of Massachusetts Residents, Fourth Edition*.

What Is the State Already Doing to Enroll the 106,000?

The Romney Administration has taken up the daunting challenge of improving Massachusetts' already high Medicaid participation rate. The approach so far involves three major initiatives:

1. The *Virtual Gateway* is the Executive Office of Health and Human Services' (EOHHS) web-based program that includes a catalog, screening and referral tools, and intake forms for a variety of health and human service programs, including MassHealth. The intake function is designed as "a single, online data collection tool for registered [health and social service] providers to create applications for multiple EOHHS programs on behalf of clients."⁹ What this means is that MassHealth-eligible people applying for other EOHHS programs (such as WIC, child care subsidies, Food Stamps, and others) through the Virtual Gateway are therefore more likely to learn of their eligibility for MassHealth and may more conveniently apply for the program. The web-based tool is being phased in, and is currently in use at a limited number of provider sites across the state.
2. The state now requires that *applications for the Uncompensated Care Pool* be made jointly with a MassHealth application. Previously, people could apply for Pool support independently and were not required to apply for MassHealth even if probably eligible. Under the new rules, MassHealth-eligible Pool applicants will be enrolled in MassHealth instead.
3. The *MassHealth Technical Forum* (MTF) is a collaboration of the Office of Medicaid, which administers the MassHealth program, and the University of Massachusetts Medical School's Office of Community Programs. Its purpose is to provide a locus of communication between the MassHealth program and health care providers and consumer advocates across the state, with the goal of improving education and awareness of, and enrollment in, MassHealth. MTF holds quarterly meetings in five regional locations, facilitating an on-line communication network, and maintaining a website to transmit information.¹⁰

In addition to these initiatives, the Romney Administration included \$250,000 to support MassHealth outreach activities in its Fiscal Year 2006 budget proposal.

⁹ <https://vgportal1.hhs.state.ma.us/portal/dt>

¹⁰ <http://www.ocp-map.org/Programs/MTF/>

These efforts, while laudable, may not be sufficient. There are barriers to enrolling or retaining eligible MassHealth members, many of which are not new and not specific to Massachusetts, and may be beyond the reach of the State's existing efforts. These barriers include:

- Lack of awareness of eligibility.
- Complicated, time-consuming application process.
- Fear about applying for MassHealth.
- Stigma associated with MassHealth.
- Confusing communication among the state, health care providers, and the public.

Interviews we conducted for this report identified additional challenges. The MassHealth program has chosen or been mandated by the legislature to make a number of policy and procedural changes over the past several years. While not necessarily intended to do so, our interviews suggest that these changes have had the practical effect of exacerbating barriers to enrollment. These changes are described in the "Findings from Interviews" section:

1. Reduction or elimination of resources that supported a systematic approach to increasing and maintaining enrollment.
2. Frequent changes in eligibility standards that create confusion about who can qualify for MassHealth.
3. Changes in application and redetermination processes.
4. Communication barriers resulting from staffing and organizational changes at MassHealth and EOHHS, confusing written communication, and reduced capacity to address cultural and linguistic differences.

Any future efforts to enroll the remaining eligible but uninsured people should be designed to address the reasons these people are not already enrolled in the program. The remainder of the report examines some of the identified reasons and concludes with a recommendation for how to move forward.

Methodology

The information reported here was gathered in a series of telephone interviews with 11 community and business stakeholders between October and December 2004. Interviews were conducted with representatives who work in a variety of settings, including

- health care delivery sites;
- grassroots social service organizations;
- consumer groups; and

- a managed care organization with Medicaid enrollees.

The reported findings represent only the views and experiences of these informants and do not statistically represent a larger group. All of the interviewees are very familiar with MassHealth in general and with the processes for establishing and maintaining eligibility, as well as with the experiences and attitudes of actual and potential MassHealth members. There was considerable consistency in our interviews in both the themes identified and specific examples offered.

Representatives of the Massachusetts Office of Medicaid reviewed and commented on drafts of the paper. Their views are partially but not totally reflected in the final report, and the Office of Medicaid does not necessarily agree with the findings.

Findings From Interviews

1. **Though there are efforts to make enrolling in MassHealth easier for those who seek assistance, there currently is no organized approach by the state to reach out to harder-to-find groups.**

Increases in MassHealth enrollment in the late 1990s were the result of clearly targeted, organized efforts that were an integral, funded part of the MassHealth eligibility expansion.

At that time the state increased its engagement with private sector partners to perform education and enrollment work: some efforts were carried out by the state alone, some were collaborations with private sector organizations such as community health centers, hospitals, or community organizations, and some were solely the purview of those in the private sector. Examples of these efforts included the “**Campaign for Coverage**,” state funding for **provider outreach workers**, **Mini-Grants** from the state to community organizations, and **state outreach workers**. All of these expanded or newly developed programs were funded, at least in part, by the state.

- The state worked with the Massachusetts Hospital Association and other groups to create a marketing campaign called the “Campaign for Coverage,” which included elements aimed directly at potential MassHealth recipients, as well as training materials for hospital and health center staff to use in assisting people to apply. Part of the power of this campaign was the consistency of the message across a wide variety of settings, which helped ensure an accurate understanding of MassHealth by potential members. Because the materials were professionally designed and commonly used, they contributed to an improvement in the image of MassHealth and its members.

- The state shifted the locus for applying for MassHealth from its office to those of its community collaborators. It began the process of regionalizing the MassHealth Enrollment Centers (MECs), closing some of them. At the same time, though, there was an increase in the number and type of community sites – including social service and consumer groups in addition to health care delivery sites – where MassHealth applications could be made. This change in the locus of the work to the community level had the positive results expected, and remains in force today. However, with reduced funding from the state to support the work, some of the social service and consumer groups have not been able to continue their commitment to health access work. In addition, a concern as the state moves toward fuller implementation of the Virtual Gateway is that smaller organizations may not have adequate information technology capacity to continue supporting their clients in the MassHealth application process. This difficulty may be mitigated by the state’s willingness to allow these organizations to continue to file paper applications.
- The state awarded “Mini-Grants,” which provided funding of up to \$20,000 to community-based health care, social service, and advocacy groups, to support those groups in reaching out to potential MassHealth recipients. Organizations used the Mini-Grants for a variety of purposes, including the development of new health access counseling and advocacy, and the creation of Health Access Networks, which were a means for regular discussion between the community and MassHealth representatives. Over \$2.5 million was awarded over the five-year duration of the Mini-Grant program, with as many as 70 organizations receiving grants to do outreach and marketing in a given year.
- At least as important as the change in emphasis to the community were the mechanisms for health care providers and other community members to work directly with MassHealth staff. These interactions could occur either on-site with a MassHealth outreach worker, with designated staff members at a MassHealth Enrollment Center, or through regular community meetings. The state outreach workers visited different health care delivery sites for part of each week in order to review applications, input them to the computer system, and work directly with hospital or health center staff to address problems that had arisen since their last visit. Community outreach workers developed strong working relationships with individual MEC staff, and community meetings involving supervisory- and managerial-level state employees provided an opportunity for problem-solving at the system level and a vital feedback mechanism for the state.

Beginning in the early 2000s there was an economic contraction in the state, after which there were major cutbacks in funding for previously successful Medicaid education, outreach, and enrollment efforts carried out by state and by community organizations. Budget constraints forced significant staff reductions at the MECs, and in 2002 MassHealth outreach efforts such as the Mini-Grants and Health Access Networks lost funding. The Health

Access Networks were replaced by the MassHealth Technical Forum, which conducts quarterly regional meetings.¹¹ There is a perception by some that it is oriented toward provider-based enrollment and billing staff rather than the broader constituency that participated in the Health Access Networks.

Our interviewees reported these consequences of staffing changes and reductions in program support:

- Genuine community outreach has been severely constrained, as many small organizations could not continue to do the work without the funding.
- There has been a decline in the resources available to assist cultural and linguistic minorities in accessing the program.
- Organizations that continue to provide support to MassHealth applicants and enrollees – mainly health care delivery sites – face a greater burden. This, in turn, diminishes their ability to do community outreach.
- A systematized “feedback loop” from the community to the state is no longer in place.
- Because much of the reduction in staffing at the MECs was accomplished through early retirement, the remaining staff members are, on the whole, less knowledgeable and seasoned than were their more experienced colleagues.

The elimination of a number of successful initiatives to inform people of the availability of MassHealth coverage and guide them through the process of enrolling underlies and reinforces many of the other barriers our interview subjects identified. The Virtual Gateway represents a new effort to efficiently inform and enroll. Gaps remain, though, because the Gateway is effective only to those already seeking services. Many of the consequences noted here recur in other contexts, as elaborated in the remaining discussion.

2. Changes to eligibility rules have created confusion and discouragement for some.

As eligibility categories have shifted over the last several years – by legislative mandate – it has become difficult to keep track of who is and who is not eligible for MassHealth. At the community level, where our respondents operate, confusion about who is eligible for MassHealth necessarily discourages some eligible people from applying.

Complex and frequently changing eligibility rules increase the likelihood that eligible people will not be enrolled. For instance, coverage for long-term unemployed adults was cut in April 2003, and while this coverage was restored in October 2003 it took over one year for enrollment to reach its April 2003 level.

¹¹ One Health Access Network, run by Community Partners, Inc., still operates without state financial support.

In some cases the existence of a waiting list for other state health programs may discourage potential MassHealth applicants. In one example from our interviews, when the Children's Medical Security Plan (CMSP) had a large waiting list, some parents decided not to apply on behalf of their children, as the situation seemed hopeless. The children then were not enrolled when the cap on CMSP enrollment was increased and all people on the waiting list were contacted. There was concern that a similar situation would arise with MassHealth Essential, which recently had reached its federally determined maximum enrollment level of 36,000. While the federal cap on MassHealth Essential has been lifted, allowing the approximately 3,500 people on the waiting list to be enrolled, a state limit of \$160 million annualized cost may be reached within the next several months, causing further confusion about eligibility for this category of MassHealth.

The changes in eligibility to raise income thresholds but require premiums may have expanded enrollment, but our interviewees report that the premiums are not affordable for some of the people who are eligible for the program. For some people who receive MassHealth subsidies for their private insurance premiums, delays in reimbursement have resulted in difficulties with cash flow and may deter them from remaining enrolled.

All of these difficulties are exacerbated by the reduction in resources available to do education and marketing about MassHealth. While changes in eligibility criteria may be determined legislatively, MassHealth could, with adequate resources, mitigate some of the negative effect through enhanced or modified procedures.

3. Administrative processes often remain time-consuming and cumbersome – for both the public and providers.

Interview subjects reported administrative hindrances at the application, enrollment and redetermination stages:

Application

The application process is time-consuming, and typically requires outreach workers at health care delivery sites and other organizations to work face-to-face with applicants. Changes in eligibility categories and criteria, as well as the shift to the combined MassHealth and uncompensated care application, have increased the time our respondents say they need to explain the benefit of applying for MassHealth and the documentation needed. These changes have also increased the time needed to allay fears people may have regarding the confidentiality of information they include in the application.

Income documentation can be difficult for applicants to obtain for a variety of reasons, such as being paid in cash or employers being unwilling to document that they pay less than minimum wage. Current documentation requirements make it particularly difficult for people who work an unpredictable schedule or who work seasonally to provide what is needed to obtain a MassHealth approval. And changes in documentation requirements over the past several years have created inconsistencies and confusion about what is required.

Massachusetts provides basic health coverage through the Uncompensated Care Pool and MassHealth Limited for state residents who are not US citizens or do not have a Social Security number. However, our interviews revealed that people who fall into these categories, or who are applying for MassHealth on behalf of their citizen children, may be reluctant to complete the newly combined MassHealth/Uncompensated Care application because they are concerned that information about their family will be conveyed to immigration authorities. Some documented immigrants are reluctant to apply for MassHealth because they mistakenly fear it will compromise their ability to become naturalized US citizens in the future.

Enrollment

Most non-elderly MassHealth members are required to enroll in a managed care plan, either through a private HMO or the state's Primary Care Clinician Plan. When they enroll, they must select a primary care provider. If they do not affirmatively choose one, they will be automatically assigned. If the new member does not understand this process and does not go for care to the assigned provider, they may be considered uninsured for the care provided and consequently may be billed directly for that care.

Redetermination and Maintaining Enrollment

MassHealth members must redetermine their eligibility at least once a year by completing a form and returning it to MassHealth. MassHealth automatically disenrolls anyone to whom they send a letter that is returned undelivered. The state has modified its process to accommodate people who identify themselves as homeless on their application by exempting them from this procedure. But the automatic disenrollment does cause difficulty for people who live in situations where they are unable to put their name on the mailbox, or who move frequently and whose mail does not catch up with them.

Interview subjects stated that the sheer volume of applications, and the time required of MassHealth members and the people assisting them, has increased as a result of the state's decision in 2002 to begin to conduct redeterminations more regularly. In 2002 the time allowed for the redetermination process was reduced from 60 to 30 days (it was recently

increased back to 60 days), which means that anyone who could not complete the process within the timeframe was automatically disenrolled. In addition, some interviewees reported that redetermination forms cannot be photocopied and that MassHealth does not provide additional copies to health care providers, health plans, or advocates for use in assisting clients with the process.

Administrators of the MassHealth program experience a natural tension between the desire to identify and enroll eligible members on the one hand, and to maintain the fiscal integrity of the program on the other. This tension is manifest in the administrative requirements described here that hinder getting or retaining MassHealth benefits.

4. Communication from MassHealth to providers and the public can sometimes be frustrating and confusing.

Our interviewees report that communication with or from MassHealth frequently is difficult to understand, or is not organized in a way that would optimize enrollment.

As an example, some people who have applied for MassHealth and been rejected, but whose children may be eligible, fail to enroll their children because the letter from the state mentions their status near the top but includes the information regarding their children's eligibility near the bottom, where it may not be read.

A second example regarding the content of letters from MassHealth concerns redetermination notices going to members in CommonHealth and the HIV program, in which the state mentions the possibility of being put onto a waiting list in the future. This contributes to the mistaken belief that these programs are capped, though at this point the federally permitted caps have not yet been imposed.

An example of a technical communication problem is that redetermination forms and monthly premium notices come without return envelopes, and the redetermination form does not include the return address (though it is contained in the cover letter). So if someone does not keep the cover letter with the form, they will not know where to send the completed application. This, in turn, increases members' reliance on community outreach workers to help them complete the process.

Examples of difficulties extend to oral communication as well. Many of the people interviewed reported that people calling MassHealth from the field cannot request to speak to a particular person at a MEC. Rather, they must speak with the first available person, even if they have already worked with someone else on the same case, or they know that a particular MEC staff person has expertise in the problem about which they are calling. This

increases the time outreach workers and MassHealth staff spend solving problems, and hinders the staff in each organization from maintaining individual relationships.

Cultural and linguistic barriers persist and make problems worse for many groups. Community representatives we interviewed believe that the end of the Mini-Grants has reduced the system's capacity to deal with diversity. The Mini-Grants were the principal source of funding for some grassroots organizations to do health access work. Cultural and language issues are best addressed by locally focused community organizations. Without local, culturally-appropriate resources, patients with cultural or linguistic barriers have greater difficulty obtaining information about or enrolling in MassHealth. Difficulty obtaining insurance coverage such as MassHealth limits people's access to health care services, which in turn contributes to racial and ethnic health disparities.

While Massachusetts residents speak a tremendous variety of languages, most MassHealth materials are available only in English and Spanish. Interviewees expressed the view that the overall diminution of services designed specifically for cultural and linguistic minorities promotes misunderstanding and stigma regarding MassHealth.

What Else Can Be Done?

The Office of Medicaid has made a substantial investment in and is relying heavily upon the Virtual Gateway to increase the number of eligible people who become enrolled in MassHealth. The creation and implementation of this web-based tool, which serves as a portal to all possible services regardless of initial entry point, is an important innovation. It may well help the state achieve its objectives of increasing the percent of eligible residents who are enrolled in MassHealth, thus decreasing demand on the Uncompensated Care Pool and reducing the overall number of uninsured residents in the state. The full, successful implementation of the Virtual Gateway cannot alone achieve the maximum possible MassHealth enrollment, however. It can provide an effective means to identify eligible people and facilitate their MassHealth application when they seek services (usually health care services). Similarly, the Uncompensated Care Pool/MassHealth uniform application will direct people who are already engaged in the health care system into MassHealth. Neither of these initiatives address the challenges of enrolling people who do *not* seek services – the outreach component of the MassHealth application and enrollment process – nor will it keep those already enrolled from becoming disenrolled – the retention component.

The most effective strategies to enroll eligible people should be crafted based on broad, detailed information about specific populations, their knowledge and views about

MassHealth, and the barriers to enrollment they face. To develop this information and craft the strategies, the State should create a new **Outreach, Enrollment, and Retention Workgroup** to take advantage of the collective talent and wisdom of people from a variety of settings within Massachusetts.

The Workgroup would be charged with discerning and recommending the most suitable approaches to finding and enrolling the remaining MassHealth-eligible residents and would:

- be comprised of representatives from various settings, including state government, health care providers, policy experts, and consumers;
- distinguish among the challenges associated with outreach, application, and retention;
- determine the most important aspects of MassHealth from the point of view of potential enrollees; and
- review and build upon the work conducted in other states; in order to
- make recommendations for modified or new outreach, enrollment, and retention processes and
- identify costs, necessary investments and possible funding sources to implement its recommendations.

There are many examples of mechanisms to improve Medicaid outreach, education, application and retention that have been proposed or tested in Massachusetts or in other states. California is one state that implemented a number of strategies to boost both initial enrollment and retention. The state has

- used *market research and social marketing techniques* to better understand the perceptions and needs of potential Medicaid enrollees in order to design interventions that are likely to succeed in increasing enrollment among its “target market”
- implemented many *new processes*, such as
 - distributing lists to health plans of their members whose redetermination dates are upcoming,
 - accepting change of address information about enrollees from health plans, and
 - using case workers to follow-up with applicants or enrollees about administrative requirements for enrollment and redetermination.

These are but a few examples of the types of specific recommendations the Workgroup might produce, after examining in depth the factors that most affect enrollment and retention for various groups. The interviews conducted for this paper suggest at a more general level the areas where the Workgroup should focus its attention:

- Strengthen MassHealth’s administrative infrastructure.

- Market the program across the state.
- Support the private sector in doing enrollment.
- Create additional mechanisms for regular communication between the state and communities.

Strengthen MassHealth’s administrative infrastructure

The Executive Office of Health and Human Services operates the nearly \$7 billion MassHealth program with an administrative budget of about \$150 million. This low level of administrative cost is unheard of among private sector health insurers; for MassHealth, though operating a complex program within this constraint demonstrates an admirable efficiency, the constraint is ultimately inhibiting. When large-scale program changes or implementation is required, as is currently the case in planning for the start of the Medicare drug benefit in 2006, implementing the Virtual Gateway, and negotiating the MassHealth waiver renewal with the federal government, routine program administration could suffer. And it is the routine program administration that, in the end, has the greatest effect on how well MassHealth does in enrolling and maintaining members.

Market the program across the state

During a time of economic contraction the state has focused its resources on the delivery of health care services rather than the advertisement of the program. But marketing and outreach must be part of any serious plan to increase enrollment. The marketing must be creative and well-focused because the “target audience” is, by definition, the hardest-to-reach group of MassHealth eligibles.

Implementing a marketing program would help meet the objective of increased enrollment, not just by educating possible participants of MassHealth’s existence, but also:

- it would help manage the stigma associated with receiving “public assistance;”
- it could debunk myths that keep eligible people from applying; and
- it would help reach people who have not already sought health care services.

The Governor’s FY 2006 budget proposal includes \$250,000 to use for “enrollment outreach grants” to public and private non-profit organizations. While this is a step in the right direction, a comprehensive marketing campaign will require more funding.

Support the private sector in doing enrollment

The state embarked on a transition from a centralized to a community model for MassHealth enrollment at the program's inception in the late 1990's. However, the trend over the ensuing years has required an ever-greater investment of labor by private sector organizations even as the state's financial support to those organizations for performing the work has decreased. Certainly, health care providers in particular have a financial incentive in addition to a moral commitment to support their patients in enrolling in the best possible health insurance programs. But the state has an obligation to recognize and compensate that effort, rather than shifting the responsibility without the reward.

The mechanisms used to support the private sector now may differ from those used in past years, but there must be an explicit financial investment by the state that provides direct support to the organizations working face-to-face with clients to enroll people in MassHealth.

Create additional mechanisms for regular communication between the state and communities

Each case of a positive report about the enrollment process by someone interviewed had at its root a high quality, systematized, frequent method of communication between the state and the people at that organization. In one case, good results came from regular monthly meetings carried out since 1996. In another case an organization had a regular means of engaging in joint problem solving in its role as a pilot site for the Virtual Gateway implementation.

These examples demonstrate the importance of establishing relationships and communication between the state and the community, but they are not sufficient, as manifest now, to achieve the desired results in increased MassHealth participation. The state should consider ways to re-establish regular two-way communication with people working on MassHealth enrollment. These communication mechanisms should be designed to address a variety of topics (e.g., policy, operations), and should function at multiple levels in both the state's and the community organizations' organizational structures.

Conclusion

A recent article in the health policy journal *Inquiry* documents "the first rigorous evaluation of the impacts of MassHealth, Massachusetts' ambitious effort in the late 1990s to expand

coverage to the entire low-income population,” and finds “clear evidence that MassHealth led to an expansion of insurance coverage ...” and that “[t]he success of MassHealth provides support for the value of investing in ambitious new state efforts to find effective strategies to reach the remaining uninsured populations.”¹² Further, Massachusetts’ consistent and marked success at enrolling eligible children in Medicaid also tells us that even higher Medicaid participation rates can be achieved with the right combination of public and private sector involvement. In order to achieve these higher Medicaid participation rates and to realize the benefits of the corresponding reduction in the number and rate of uninsured people in Massachusetts, any number of public and private sector strategies are possible, including: strengthening the administrative infrastructure of MassHealth; marketing the program statewide; increasing support to the private sector to do enrollment; and creating new mechanisms for regular communication between the state and the communities.

To strengthen the entire health care system, Massachusetts must remain a leader in Medicaid enrollment rates. Now is the time for the entire concerned community to work together to continue our tradition of excellence and to develop new, collaborative approaches to all phases of MassHealth enrollment. Working together, the public and private sectors can identify the most promising tactics to keep enrollment of eligible residents in MassHealth high, looking at the outreach, education, initial application, and retention phases of the process.

Whatever approaches are identified, these strategies must be supported at the highest levels of government, both in spirit and with appropriate funding, in order to succeed. It must be clear to all concerned that enrolling all eligible people is the goal, and steady progress toward that goal is the measure of success.

About the Author

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¹² Long, S., and S. Zuckerman. 2004. MassHealth Succeeds in Expanding Coverage for Adults. *Inquiry* 41: 268-279.