Advocate, Enroll: Dual Strategy for Catholic Hospitals

By KATHERINE HOWITT and KATE LEWANDOWSKI

When it comes to caring for the most vulnerable Americans, there is one provision in the Affordable Care Act (ACA) that matters more than any other: the Medicaid expansion. If it is implemented properly in 2014, the lowest-income Americans will, for the first time, have access to high quality, affordable care.

The Medicaid expansion also means the providers who are committed to caring for these vulnerable Americans will finally be regularly reimbursed for their services; they will no longer be forced to choose between honoring their mission to serve the neediest and protecting their margins from uncompensated care costs.

But these gains are far from guaranteed. First, states must take up the Medicaid expansion. And second, the people eligible for this coverage must be enrolled. In fact, enrollment efforts are needed with or without the Medicaid expansion, since millions of uninsured Americans today are *already eligible* for Medicaid under current eligibility criteria.[1]

Proper implementation of the Medicaid expansion will be complex. Fortunately, the very hospitals that would be hurt by its failure are well positioned to help ensure its success.

TAKING UP THE EXPANSION

The recent Supreme Court ruling on the ACA opened the door for states to reject the Medicaid expansion. The consequences could be devastating.

The Medicaid expansion — if implemented in every state — is expected to extend coverage to more than 15 million adults.[2] Because the law provides no alternative source of coverage for most of them, millions of the most vulnerable and lowest-income people will be left uninsured if states reject the expansion. That means these low-income adults will continue to delay and forgo needed health care treatments, suffer worse health outcomes and struggle with higher levels of medical debt than their insured neighbors.[3]

And because fewer people would have insurance, if states reject the expansion, hospitals would continue shouldering the financial costs of caring for the uninsured and the moral burden of sometimes having to refuse them lifesaving treatments. The financial harm of rejecting the expansion will be exacerbated because the ACA cut Disproportionate Share Hospital (DSH) payments — the federal funds that help compensate hospitals for caring for the uninsured. This cut will happen whether states take up the expansion or not.

Fortunately, the Medicaid expansion is not only a moral imperative and a financial necessity for hospitals, it's also a fiscal win for states. The federal government will pay the entire cost of covering the newly eligible for the first three


ENROLLMENT FORM
If you are completing this application for someone else,
answer the questions as they relate to that person.
Name
Street Address
City, State, ZIP
Relationship to
Self
Date of Birth
Gender:
Male
Female
Social Security Number
Home Phone Number
Marital Status
Place of Birth
Alien Registration

years and will continue paying the majority of the costs after that. That leaves a relatively small share of the cost left to states. Studies have shown that the expansion would actually save money for many states because state spending on uncompensated care and other costs associated with the uninsured would drop by more than the relatively small costs associated with the expansion.[4]

Since opting out of the expansion would mean rejecting huge sums of federal dollars, leaving millions uninsured and sticking hospitals with higher uncompensated care costs, most — if not all — states will eventually take up the expansion. The question is, how long is "eventually," and can we afford to wait?

Governors in a few states have said they oppose the expansion, and dozens of others have remained noncommittal. To ensure that all states take up the expansion in 2014, the two groups with the most at stake in the decision — consumers and hospitals — must partner together to engage in a concerted, coordinated, well-resourced campaign. Together, they can educate policymakers and the public about the fiscal and moral necessity for expansion.

The first step for interested hospitals is to connect with engaged consumer groups on the ground in their state to see how they can collaborate and coordinate efforts. At Community Catalyst, a national nonprofit advocacy organization based in Boston, we partner with these consumer groups in over 40 states; hospitals interested in connecting with this movement in their state should feel free to contact us.[5]

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HOSPITALS CAN HELP BUILD THE CASE

Local legislators may be unaware that rejecting the expansion would have negative financial consequences for hospitals in their district. Hospitals can help inform them by producing concrete financial analyses of the impact that rejecting the expansion would have on the institution, taking into account the increased uncompensated care costs and the reduction in DSH funds.

This analysis can be even more impactful by looking beyond the hospital's bottom line to the effect on the local economy. Will the hospital be forced to increase rates charged to private insurance companies to compensate for these losses? Will the financial hit affect the hospital's ability to create new jobs?

The provider community also can help build the moral case. Hospitals are already serving many of the low-income adults who will qualify for Medicaid under the expansion. If the individuals are currently uninsured, hospitals may be limited in the services they can provide; financial realities may force hospitals to deny them chemotherapy or long-term, lifesaving treatments that do not qualify as emergencies until the patient is in crisis. For these patients, Medicaid could be a lifeline. By encouraging physicians, nurses or the patients themselves to tell their stories, hospitals can help put a human face on the consequences of failing to expand Medicaid.

HOSPITALS CAN ENGAGE POLICYMAKERS

Hospitals can use their status as employers and important community institutions to gain one-on-one meetings with whomever represents their district in the statehouse and with the governor's office. They can use this valuable face time to educate these key decision-makers on the financial and moral case for the expansion.

Hospitals also can garner additional attention by holding a press event to highlight the importance of the expansion to the community. By partnering with a diverse group of consumer groups and other local stakeholders for these events, hospitals can magnify their influence.

Hospitals can engage their employees and board members to make the case. Hospital board members are often well-respected, high-profile

people in their communities. Doctors and nurses are very well-trusted by the public, making them great spokespeople for the expansion. If these employees and board members live in different districts from the hospital itself, engaging them can help reach and educate more decision-makers. These employees or board members can explain the implications of the Medicaid expansion for the hospital and the local community by writing letters to the editor in local newspapers, holding their own meetings with local legislators and speaking at hospital- or consumer-led press events.

HOSPITALS CAN HELP BUILD THE BENCH

Hospitals active on this issue can help bring their peers to the table. They can meet with less-engaged hospitals, share financial analyses to help them understand how the Medicaid expansion could affect them and offer concrete ideas for engaging in the debate. Engaged hospitals can also organize a sign-on letter for other hospitals, calling for the state to take up the expansion; this offers a less resource-intensive way for other hospitals to weigh in, while magnifying the message that the more-engaged hospitals are carrying.

Individual hospitals can make their voices heard in their state's hospital association and encourage them to take action in support of the expansion. Hospital associations in some states have issued public statements calling on their state to take up the expansion.[6] Even if associations shy away from such bold public action, they can hold private meetings with key decision-makers or lend resources to the broader campaign.

ENROLLING PEOPLE IN COVERAGE WITH OR WITHOUT THE EXPANSION

Although expanding Medicaid eligibility is an important way to increase coverage, another path to increasing enrollment exists in every state. Across the country, millions of people are currently eligible for Medicaid — even without the expansion — but are unenrolled. Providers have a great opportunity to reach out to this population and connect individuals to Medicaid coverage.

Individuals may be eligible but unenrolled for a variety of reasons. In some cases, eligible individuals or their family members may not be aware that programs are available for them.

Even people who have enrolled in Medicaid before may be unenrolled later if they churn out of the system because of income fluctuation, incarceration or another change in eligibility. They may not realize they have become eligible once again.

Moreover, even if unenrolled individuals know they or their family members are eligible, they face other barriers to enrollment. Signing up for Medicaid takes time to fill out the forms, to gather supporting documents, to sort out questions about the process or seek translation services — time that some individuals might not think they can spare. Stigma and fear of government entities (or cultural barriers) might stop others from enrolling.[7]

Eligible but unenrolled individuals may be disconnected from other social services, too, and not know how to begin the enrollment process.

For these eligible but unenrolled individuals, each interaction with a health care provider can be a crucial opportunity to be educated about their coverage options, screened for Medicaid eligibility and even enrolled in the program.

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HOSPITALS CAN EDUCATE THEIR COMMUNITIES ABOUT COVERAGE OPTIONS

The Children's Health Insurance Program (CHIP) is a useful example of effective outreach leading to increased enrollment. When CHIP was launched in 1997, enrollment was slow at first. However, as states undertook dedicated campaigns to promote awareness of CHIP after the CHIP Reauthorization Act passed in 2009, more eligible children enrolled. Provider organizations used a range of efforts to publicize the program, from a neighborhood health center that entered a "Got Insurance?" float in a neighborhood parade to a health system that gave patients business cards with the message "helps with insurance" to distribute to

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family and friends.[8] Between 2008 and 2009, the number of Medicaid- and CHIP-eligible children who were unenrolled fell from 4.7 million to 4.3 million, even as 3 million children became newly eligible in that time.[9]

HOSPITALS CAN BREAK DOWN BARRIERS

In order for provider organizations to connect eligible but unenrolled individuals to Medicaid coverage, organizations need to have appropriate resources in place. When patients arrive at the hospital or other provider site, part of the patient intake process can be a screen for Medicaid eligibility, which could be flagged for a social worker or other enrollment counselor.

Hospitals can screen patients for Medicaid or CHIP eligibility under current criteria, and they can also identify people who might qualify for Medicaid after the expansion is implemented in 2014. Hospitals can then do outreach to those individuals in 2014 to inform them of their potential eligibility.

HOSPITALS CAN RAMP UP THEIR EFFORTS

Bearing in mind that eligible but unenrolled individuals may lack access to a broad range of services, provider organizations could promote the availability of counselors to assist in enrollment for other programs, such as the Supplemental Nutrition Assistance Program (SNAP) and Social Security.[10]

Importantly, Section 2202 of the ACA provides states with the option to designate provider organizations that can make determinations of "presumptive eligibility" for Medicaid and CHIP. This option would allow providers to enroll patients they deem eligible for Medicaid or CHIP on the basis of a preliminary review into temporary coverage; it would qualify those providers to receive payment for services delivered to these patients on that visit, and it would allow patients to receive follow-up care without waiting until their full application has been processed.[11] Hospitals can encourage their state officials to take up this option.

HOSPITALS CAN TAKE ENROLLMENT INTO THE COMMUNITY

Hospitals can take enrollment assistance out into the community rather than wait for consumers to come to them already sick. For example, one hospital in Massachusetts staged a community breast cancer screening. In addition to offering free mammograms, the hospital staffed the event with enrollment counselors who screened attendees for Medicaid eligibility and helped women get enrolled.[12]

HOSPITALS CAN LEAD THE WAY

The business case for the Medicaid expansion is clear: Hospitals will bear the burden of caring for the uninsured. Moreover, regardless of legislation or regulation, Catholic health care leaders must recognize the need in their communities for accessible coverage and care. With these parallel imperatives in mind, it is time to go into neighborhoods and statehouses. Working to ensure your state takes up the Medicaid expansion and to enroll people in Medicaid, newly eligible or not, are powerful ways to ensure that some of the most vulnerable seek and receive the care they need.

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NOTES

1. Genevieve Kenney et al., *Opting Out of the Medicaid Expansion Under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?* (Washington D.C.: Urban Institute Health Policy Center, July 2012) www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf.
2. Kenney.
3. Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* (Cambridge, Mass.: National Bureau of Economic Research, July 2011) www.nber.org/papers/w17190.pdf?new_window=1.
4. A national study by the Urban Institute found that in aggregate, states would see net budgetary savings of $40.6 billion to $131.9 billion over five years if they all took up the expansion (see www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf.) The state of Arkansas ran the numbers and found that the expansion would save it $372 million over six years (see

http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/07/18/arkansas-says-medicaid-expansion-saves-372-million-lets-break-down-those-numbers/).
5. Please visit our website for information on state advocacy efforts or for contact info: www.community-catalyst.org.
6. For example, the Iowa Hospital Association board recently voted unanimously in favor of the Medicaid expansion. It plans to aggressively lobby state legislators to take up the expansion. See www.desmoinesregister.com/apps/pbcs.dll/article?AID=2012308290052&nclick_check=1.
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8. Sue Kane, "EOHHS Enrollment, Outreach and Access to Care Grants — Direct Service Outreach Grants," *Nov. 2009 Summary Report* (Shrewsbury, Mass.: UMass Medical School Center for Health Policy and Research) www.outreachgrants.org/uploadedFiles/Outreach_Grants/November%202009%20Direct%20Service%20Report.pdf.
9. Phil Galewitz, "CHIP Outreach Gets More Kids Covered," *Capsules, the KHN Blog*, accessed Sept. 26, 2012. capsules.kaiserhealthnews.org/index.php/2011/08/chip-outreach-gets-more-kids-covered/.
10. Kane.
11. Nevada Department of Health and Human Services dhhs.nv.gov/HealthCare/Docs/policypapers/Section2202-PresumptiveEligibility.pdf.
12. Sue Kane, "EOHHS Enrollment, Outreach and Access to Care Grants — Direct Service Outreach Grants," *December 2010 Summary Report* (Shrewsbury, Mass.: UMass Medical School Center for Health Policy and Research) www.outreachgrants.org/uploadedFiles/Outreach_Grants/December%202011%20Direct%20Service%20Report_Final.pdf.

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