Assessing the Louisiana State Solutions Project

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Introduction

This report presents findings from an assessment of the Louisiana State Solutions Project carried out at the request of the Louisiana Department of Health and Hospitals, with support from the Rutgers Center for State Health Policy, National Program Office of The Robert Wood Johnson Foundation's State Solutions Initiative. The assessment involved semi-structured interviews with staff of the Medicaid program in Louisiana at the State and regional offices who were directly involved in designing and implementing the project, and with staff from organizations with whom Medicaid staff created partnerships to support their work.

The primary goal of the project was to increase enrollment of eligible citizens of Louisiana in the Medicare Savings Programs (MSPs). Additional goals addressed improving the administrative efficiency of enrollment and re-enrollment in these programs, improving related computerized information systems for the program, raising the positive profile of the State Medicaid program among the public and among a wide range of agencies and groups, and increasing the capacity of Medicaid staff to communicate effectively with the public.

To facilitate their work, regional offices built partnerships with hundreds of organizations, including health-related agencies, social service providers, faith based groups and commercial enterprises. Partners' involvement ranged from relatively limited (displaying MSP applications prominently) to moderate (helping clients complete applications) to active (informing and referring clients, inviting regional staff to participate in events, and even creating events at which MSPs could be presented to their staff or clients).

The project made substantial progress in achieving not only its primary goal but its additional goals as well. Staff carried out over 28,000 hours of outreach, nearly three times the minimum required, participating in over 1,800 events and nearly 800 in person presentations to groups. Enrollment grew substantially, from 97,512 persons in January, 2001 to 137,151 persons in June, 2005. This represents an increase of 39,639 people, or 40.7 percent.

Administrative processes for enrollment and renewal were simplified, leading to both greater ease of enrollment for those eligible and to cost savings for the State. Progress was made in achieving consistency between State and Federal statistics on enrollment. The work of the regions, independently and through their partnerships, substantially improved the level of trust of Louisiana's citizens in this State government agency. Partners reported a high degree of reciprocity and mutual benefit in their relationships with regional teams, characteristics which are associated with high likelihood that such relationships will be sustained over time. Regional staff reported significant gains in their level of comfort and skill in making presentations in public. Perhaps more important, involvement in these efforts gave them considerable gratification because of their commitment to meeting the needs of the target population – the low-income elderly and people with disabilities.

Several factors appear to have contributed to this success, including: staff commitment and competency at both the State and the regional levels; the ability of MSP to build on the experience and infrastructure created in earlier outreach and simplification efforts for the LACHIP program; supports such as availability of overtime pay, travel reimbursement, promotional items and training made available through the grant itself; and support from partners. The project did face challenges and barriers to achieving even greater progress. These included inconsistent managerial support across regions, inconsistent performance across regions, and insufficient time to build State level partnerships.

Funding from the State Solutions Initiative has now ended, but it is essential to maintain and indeed to further strengthen both the capacity of Louisiana to enroll eligible people with Medicare into these special programs and the actual number of people enrolled and appropriately retained on the rolls. Indeed, the devastation wrought by Hurricane Katrina may mean these supports are needed by an even greater proportion of Louisiana's seniors and people with disabilities. At the same time, since enrollment in an MSP gives individuals immediate and easy access to the new Medicare prescription drug coverage, its value has in fact increased.

We make the following recommendations to sustain and enhance the Louisiana MSP efforts:

1. Make clear that outreach and enrollment for MSP is and will remain a high priority at both the State and regional level.

2. Maintain the regional teams and support of those teams by senior regional managers.

3. Identify a "point person" for MSP outreach efforts at the State level, to provide information, serve as a resource, and continue to track and analyze patterns in outreach and enrollment.

4. Continue to make educational materials and promotional items available to regional staff.

5. Maintain strong working relationships with partners.

6. If possible, continue to make overtime payment (rather than compensatory time off) available to staff who participate in outreach events on weekends and in the evenings.

7. Continue to improve the simplicity and thus the efficiency of enrollment and renewal processes, as well as the information systems that support these processes.

Introduction

In 2001, The Robert Wood Johnson Foundation (RWJF), building on the success of its Covering Kids Initiative, which was designed to increase enrollment of children in Medicaid, SCHIP and private insurance, began a smaller effort to increase enrollment of low-income people with Medicare in the various Medicaid programs that provide them with health care coverage assistance, i.e., the Medicare Savings Programs (MSP). This National Program, which was conducted in collaboration with The Commonwealth Fund, was called "State Solutions." The State of Louisiana Department of Health and Hospitals received a grant from the State Solutions Program, the only grant going to a State Agency operating a Medicaid program. The three-year grant to the Department of Health and Hospitals began in 2002 and came to an end in August 2005.

As with many of its initiatives, RWJF created a National Program Office (NPO) for State Solutions, in this case at the Rutgers Center for State Health Policy. In the Spring of 2005, Louisiana's Medicare Savings Program (MSP) requested from the NPO at Rutgers Center for State Health Policy, that a consultant, Dr. Shoshanna Sofaer, be made available to them to review the program's efforts, document its accomplishments and how they were achieved, and identify areas where improvements could further enhance Louisiana's efforts to serve low-income people with Medicare. Louisiana also requested that Dr. Sofaer attend and make a presentation at the MSP Annual Meeting in Spring of 2005, the last such

meeting to be conducted under the auspices of the project. The Rutgers Center for State Health Policy retained Dr. Sofaer to participate in the Louisiana Annual Meeting, conduct the assessment and then return to Louisiana to present her findings and discuss them with key officials and stakeholders. This document presents Dr. Sofaer's assessment of Louisiana's MSP efforts and her recommendations on how to sustain and improve it.

This report begins with a brief description of the methods used to collect and analyze data. We then present our findings, which include a description of the MSP program goals and structure, the roles of the central office, the regional teams, and the partners; key program accomplishments; factors identified that supported those accomplishments; barriers faced by the program in pursuing its objectives, and areas where the program could be improved. Finally, we present our conclusions and recommendations, with an emphasis on which program elements are most essential to sustain going into the future.

Methods

We began our work by contacting and talking informally with Ms. Sandra Whitten, the Louisiana MSP Project Director, and Ms. Ruth Kennedy, Deputy Director of Louisiana's Medicaid program, who oversaw the effort. Based on what was learned in these conversations, Dr. Sofaer conducted two informal focus groups at the Annual Meeting with members of MSP regional teams. The purpose of these group discussions was to begin to learn how MSPs were organized, how the regional teams worked with local partners, what facilitated the work of the teams and what barriers they faced. The focus groups provided extremely useful background that helped us refine our research plan and data collection instruments.

The primary method we used to conduct the assessment was semi-structured key informant interviews. In such interviews, a protocol is developed which articulates a series of open-ended questions to elicit, without "leading" the respondent, the perceptions, experiences and knowledge of people actively involved in the activities under study. Protocols generally also include what are called "probes," which are used to gather further detail, to clarify responses, or to inquire about specific issues that may not have been mentioned in the "open-ended" response.

In this study, interviews were conducted with two groups of people: (1) members of the MSP team in each of the nine regional offices (a total of 18 people) and (2) liaison staff in a sample of partners who worked either with a particular region or at the state level (a total of 5 people). Copies of the two distinct protocols used for these interviews can be found in Appendix A. More formal interviews were also conducted with Ms. Whitten and Ms. Kennedy, after all other interviews had been completed. This timing permitted us not only to get their perspectives on the issues addressed in the other interviews, but also to follow up on statements made in those previous interviews, without revealing the source. Note that all persons interviewed were assured that their responses would be kept confidential; this was done both in the spirit of protecting human research subjects and to encourage as much candor as possible among those interviewed.

All interviews were conducted by telephone. Interviews were either tape recorded, or responses were transcribed simultaneously while the interview was being conducted. Responses to each question were summarized and arrayed so that themes and patterns could be identified. This classic qualitative data analysis is the basis of this report.

Findings

Program Goals

In keeping with the intent of the State Solutions initiative, the primary goal of the Louisiana effort was to increase enrollment of low-income people with Medicare in the state in the various Medicare Savings Programs. These Medicaid programs provide, for people at different levels of income and/or assets, additional benefits and/or assistance in paying Medicare Part B premiums, deductibles and co-payments. Typically, low-income people are not in a financial position to purchase private supplemental policies (Medigap policies) on the open market, nor do they often have access to such supplements through their own or their spouse's former employer. In some parts of the country, low-income people have, at various points in time, been able to join Medicare HMOs at relatively low or no premiums, to cover these costs, Unfortunately, such plans have been available far less often in Louisiana, and indeed in most rural areas of the nation. In this State, therefore, Medicare Savings Programs are vital to protect the health and finances of low income people with Medicare.

Enrollment in MSPs helps low-income citizens in Louisiana avoid having to make choices between paying their utility bills, putting gas in the car, buying food and even paying their real estate taxes on the one hand, in order to pay for health insurance and/or health care on the other. Indeed, in many cases, seniors and people with disabilities who are faced with these "trade-offs" resolve them by delaying needed medical care, not filling prescriptions for needed medications, and thus suffering health consequences that can often be life-threatening for the individual and lead to high medical care costs for society.

Although increasing enrollment in Medicare Savings Programs is a worthy goal, in Louisiana, involvement in the State Solutions initiative also supported related aims, including the following:

- Increasing the capacity of Medicaid program staff to communicate effectively with the public;
- Creating and sustaining strong working relationships with a wide range of partners at the state and local level;
- Simplifying and thus reducing the costs of administrative, eligibility and enrollment procedures; and
- Enhancing the scope and effectiveness of computerized information systems in order to improve data quality, increase efficiency and maintain enrollment of eligible individuals.

This report addresses how well these related aims were achieved, as well as the major goal of increased enrollment.

The program's structure had three key elements: a central project staff, regional teams, and the involvement of a variety of state and local level partners. Each element is discussed below.

Central Project Staff

The Louisiana State Solutions project was housed in the office of the Director of Program Eligibility of the State Medicaid agency. Ms. Donna Dedon, the head of this office, was, in the words of one respondent, "the heart and soul" of the project until her recent retirement. The day to day coordinator of the project, since joining in August 2002, was Ms. Sandra Whitten. Ms. Whitten served as the primary point of contact between the project and the NPO and RWJF. As noted before, Ms. Ruth Kennedy was the highest ranking state official with direct oversight of the effort.

The central office project staff played a wide range of roles, including the following:

- Collecting and aggregating information from the regions on their activities and accomplishments;
- Creating and disseminating a project newsletter and an MSP video;
- Designing, having produced, and distributing a variety of promotional items which were used at outreach events;
- Creating attractive informational materials for the public that were at an appropriate reading level;
- Developing and maintaining working relationships with state level partners such as the Louisiana SHIP program, which is housed in the state insurance agency;
- Answering questions from and serving as a resource to regional teams;
- Creating systems to collect accurate data on outreach efforts and related information, such as the number of enrollees who had passed away each month or the number of enrollees whose cases were closed "procedurally," for example because of the lack of a renewal form or verification;
- Reconciling enrollment figures in the State's records with those in the records of the Centers for Medicare & Medicaid Services (CMS);
- Simplifying enrollment and re-enrollment forms and procedures;
- Organizing regional teams each year to conduct focus groups to learn about how to reach specific groups of potentially eligible persons (e.g. seniors people with disabilities, the homebound) and supporting the delivery of training on running focus groups by a consultant retained by the NPO;
- Participating in monthly conference calls with other State Solutions grantees; and
- Participating and making presentations at two national meetings of the State Solutions Initiative organized by the NPO.

Regional Offices/Project Teams

A critical decision made early in the project was that it would be structured to maximize the involvement and the autonomy of the nine Medicaid regional offices around the State. In each of these regions, one individual was formally identified as being the Regional Coordinator for the project. However, in all regions, a multi-person team was built to actually carry out the work of the project at the local level. High level administrators were formally involved in all regions, but the regions varied in terms of the extent of involvement of these administrators in the day to day work of the project. The size and make-up of the team also varied from region to region. The teams sometimes included one or more persons whose primary responsibility was to conduct outreach, but just as often also included people who had responsibility for making eligibility determinations across multiple Medicaid programs, or for tracking the eligibility of a substantial group of people with Medicaid. In some cases, as well, the team included people not only from the region's "central" office but from more localized offices serving one or two parishes. Finally, in some regions, other members of the regional staff who were not formally a part of the team also made contributions to the effort on an as needed/as available basis.

Each region had to meet three basic requirements of the project. First, they had to document that they had provided 32 hours a month of staff time in activities related to the project, primarily outreach. Second, they had to submit regular quarterly reports to the project's central office, to be analyzed and aggregated by Ms. Whitten for transmittal to the NPO. Third, they had to participate in a variety of events and activities related to the project, including an Annual Meeting and the annual round of focus groups with key audiences.

However, regional autonomy was maintained because Ms. Whitten did not formally "supervise" any of the involved regional staff, who reported through the usual chain of command of the regional and central levels of the State Agency. This meant that the key factor determining the extent and nature of regional involvement was not hierarchy but rather motivation. Ms. Whitten could encourage, inform, support and provide resources to the regions, but she could not issue orders to them.

The regions were the "front-lines" of the Louisiana State Solutions Project. Their primary role was to develop and implement a wide range of outreach efforts to inform people most likely to be eligible for MSP about the opportunity, and to provide support to them in actually applying for these benefits. While many of these activities are carried out by members of the regional team, the team also solicits and encourages other regional office staff to participate in outreach activities.

In pursuit of their role in outreach, members of the regional teams work to find out what events are happening in the community, through local newspapers and contacts with partners, and schedule participation in as many events as possible. The events may be health fairs, heart healthy events, cholesterol screening, kids day, bayou functions, Senior Olympics, or other community activities providing resources and information to a variety of audiences. Usually the MSP outreach team will have a table at these events. They will put the event on their schedule, coordinate who is going to attend,

collect and bring all the materials needed (including tables if necessary, promotional items, decorations, tablecloths, informational items, business cards, etc.). They set up for the event and work at the event booth to give information and applications to potential clients, and help potential clients fill out the application. They give basic information and answer questions about the MSPs and other Medicaid programs. They distribute promotional items. The teams also use these events to develop more "contacts," by visiting other booths, and giving out business cards. It is important to note that such activities often took place in the evenings and on weekends, rather than during the "normal" work week. In addition, they took place throughout the often wide geographic areas covered by each region, not just near their formal offices.

Other outreach activities include:

- Making sure partner agencies have an adequate supply of applications;
- Acting as a resource person for any partner or client of a partner who needs information about MSP or other Medicaid programs;
- Attending community networking meetings, including meetings of local coalitions of agencies serving low-income people, or seniors;
- Participating in radio talk shows;
- Coordinating their outreach efforts with LACHIP or other Medicaid programs.

Once people apply, the regional staff make the formal eligibility determinations. Once people enroll, they track them over time as they would any other person with Medicaid, as the time came for them to re-enroll.

In addition, regional staff provide application forms, formal orientation and training and informal consultation to a wide range of organizations in the community who serve the target population, can inform them about MSP, and can encourage them to apply. These relationships will be discussed in greater detail below in the section on partners. What is important to emphasize here, however, is that only Medicaid staff made eligibility determinations. Partners were not empowered to make such determinations, and in fact were actively discouraged from doing so, in part because regional staff were worried that they would assume incorrectly that an individual was *not* eligible when they might indeed be eligible. Nevertheless, providing information about MSP to as many people as possible who "crossed the path" of the target population was an essential element of the outreach plan, in addition to direct interactions with potential eligibles. The promotional items created by the central office were heavily used in all outreach activities, by both regional staff and partners. These items use a stylized American flag and a generally red, white and blue color palate. This appeal to the patriotism which is strong in the State generates interest and curiosity and increases trust.

Role of Partners

Each region also had responsibility for identifying potential partners in the outreach work, developing and maintaining good working relationship with them, and encouraging them to use every opportunity to inform people with Medicare with whom they worked of the benefits of applying for one of the Medicare Savings Programs. Across the state, regional offices reported having "partnership mailing lists" ranging from 75 to over 400 organizations. As is common, however, the number of organizations who were considered to be "active partners" was lower, ranging from 10 to 45. Less active partners might do no more than display applications. Somewhat more active partners might help clients complete applications. Active partners were those most likely to go further and actively inform and refer their clients, invite regional staff to participate in their events, and even create events at which MSP could be presented, either to their staff or their clients.

The staff we interviewed from partner organizations represented what might be called the "usual suspects" vis-a-vis working with seniors on health insurance issues: i.e. the State Health Insurance Information Program (SHIP), which in Louisiana is based in the State's insurance department; two health centers dedicated to serving low-income and hard to reach people, and two local Councils on Aging, which carry out in Louisiana the same set of programs as what are called the Area Agencies on Aging in other States. However, regions recruited a far wider range of partners, including:

- Community based health care providers such as pharmacists, home health agencies, physician's offices, hospitals, nursing homes and dialysis centers;
- Social services organizations including, Councils on Aging, food banks, meals on wheels, and related service agencies for seniors;
- Churches and other faith-based organizations;
- Commercial enterprises including grocery stores, Wal-Marts, gasoline stations, drug stores, convenience stores and malls;
- Other public agencies including Social Security, sheriff's offices, family services agencies, etc.; and
- Local elected officials.

Regional staff indicated that their primary criteria for recruiting partners included:

- Having a client base with a substantial number of low-income people with Medicare;
- Having credibility and legitimacy with that target population, and thus improving the level of the population's trust in the Medicaid agency and their recognition of the potential value of MSP;
- Being able to offer access to additional agencies and organizations serving the target population; and
- Being willing to promote MSP.

Regional staff were successful in developing and working with partners because they were able to offer clear and valued benefits to them, in return for their support and involvement. These relationships were clearly two-way, with referrals and information going back and forth. Thus, regions:

- Qualified the partner's clients for Medicaid programs, including but not limited to MSP;
- Promoted the partner's programs to its clients in return for the partner's promoting MSP;
- Provided "on demand" information and answers to questions about any and all Medicaid programs; and
- Provided brochures, applications and promotional items on an ongoing basis.

Not all organizations approached by the regional offices actually became engaged, for reasons that appear to be idiosyncratic rather than systematic. Regional staff appeared to have a good balance in their approach between persevering initially and then "cutting their losses" when it was clear there was no interest.

Security case workers. Again, adopting a formalized structure can help increase the lifetime of a program.

Key Program Accomplishments

Outreach Efforts

Louisiana Medicaid had set as a target that regional staff would carry out a minimum of 864 hours of outreach each quarter, which would come to 10,368 hours for the three year grant period. In fact, staff carried out at total of 28,262 hours of outreach, nearly three times the minimum. More specifically, over the course of the grant period, staff participated in 1,811 events at which they operated an MSP "booth," gave 394 in-person presentations attended by less than 20 people, plus 372 in person presentations attended by 20 or more people. Over the course of these events, nearly 300,000 MSP applications were distributed.

Partnerships

The State MSP project office indicates that a total of 1,393 partners were recruited and engaged in these outreach efforts. This is somewhat lower than the number one would come up with if we totaled the number of people on regional partner lists, but it probably is a more accurate count of partners with whom the regions had, at least at some point in time, an active relationship.

Enrollment

Ultimately, the number of people enrolled in MSP programs is the best evaluation measure for this effort. As noted earlier, state and federal statistics on this issue were not in accord. For this report, therefore, we are using what may be the best available measure, which is the number of persons in different MSP program categories for which the Federal government made a payment.

- In the QMB program, the total number of persons enrolled, as indicated by "buy-in statistics," went from 81,806 in January 2001 to 108,382 persons in June 2005. In fact, the number stayed in the range of less than 85,000 persons until April 2003, when it jumped to over 95,000, moving steadily upward after that. This represents an increase of 32.5 percent over the three year period of the State Solutions grant.

• In the SLMB program, the total number of person enrolled went from 11,207 in January 2001 to 20,813 in June 2005. There was a gradual but substantial rise over the entire time period, leading to increase of 85.7 percent.

• In the QI-1 program, the total number of persons enrolled went from 2,683 in January 2001 to 7,956 in June 2005. Here again we see a gradual rise, leading to an increase of 296 percent.

• Overall, therefore, by June of 2005, a total of 137,151 persons were enrolled in the Medicare Savings Programs in Louisiana, up from 97,512 in January 2001[2]. This is an increase of 39,639 people, and a percentage increase of 40.7 percent.

• On a financial level, the dollar amount of the "buy-in" for Louisiana MSP went from $83.6 million in 2001 to a projected $142.8 million in 2005.

Can this be attributed to the efforts of the Louisiana State Solutions project? There is no equivalent comparison group to use to make such an attribution in formal terms, however, it is important to note that in the largest of these programs, QMB, enrollment remained at a stable level for quite a while before "taking off" at a point when the project might have been expected to be fully operational at both the State and regional levels. Indeed, at this point the project had been fully activated at the regional for about six months. This is a strong indication that the efforts of the project made a substantial contribution to the increase in enrollment.

Administrative Simplifications and Improvements

This study did not explore this aspect of the Louisiana MSP project in any depth. However, it was reported that under the auspices of the project, a number of changes were made in the enrollment and renewal processes, which had the effect of making the agency more efficient as well as more effective. For example, steps were taken to substantially simplify the processes used during the renewal process. As a consequence, whereas historically a small but distressing percentage of cases were closed at renewal because of procedural problems; after the implementation of a set of administrative reforms in the summer of 2003, such closings at time of renewal went from 2.42 percent of all renewals to about 90 percent less, or .25 percent. These simplifications represent a "win-win" situation in that the Medicaid agency saves time and money, and fewer people actually eligible for MSP fail to have their coverage renewed. Another area of administrative improvement was in the agency's computer systems, which also improved the efficiency of day to day operations.

Other Accomplishments

Across our interviews with staff and partners involved in the MSP efforts, several other accomplishments

were noted, including in particular the following:

• State and regional staff's participation in outreach and the development of positive relationships with a wide range and substantial number of partner agencies and enterprises were perceived as increasing both basic awareness and positive attitudes of the public with respect to the Medicaid agency and public employees in general. A community service and customer service ethic was clearly being communicated widely.
• Many regional staff reported having gone from being quite afraid of speaking in public to being both comfortable and skilled in doing so.
• It appears that for most staff involved with the project, morale increased significantly because of the opportunity to serve a population they considered important and in great need of assistance.

Key Factors Supporting Program Accomplishments

Staff commitment and competency
At both the state and regional level, Medicaid staff members have been highly committed to the project; they had, or developed, the competencies needed to carry it out efficiently and effectively. For example:

• Regional staff have been willing to attend events on evenings and weekends, across their regions. Many have had to "fit in" the work of outreach in addition to their ongoing responsibilities and have done so. This has been especially true of those regional staff who had caseloads in addition to explicit responsibility for outreach efforts.

• In most cases, staff have had a particular commitment to providing help to this particular target population, i.e. seniors and people with disabilities. They seem to have a very human and concrete understanding of the difference that enrollment in a Medicare Savings Program has in the day to day lives of their clients and they are very pleased to be able to help make that difference.

• Staff in the regions are very practical people. While driven by values, they are also realistic about the problems they are likely to face in generating enough trust to get a hearing with the target population. They are also realistic about dealing with their colleagues. They recognize that not all staff are going to be interested in, or especially good at, outreach work. Rather than focus on these problems, they simply move on and either find others who will be willing and able to help out, or to take on more themselves. A few have not gotten full support from their managers (see below), but here again, they simply, as the saying goes, "keep on keeping on."

• A sizable number of regional staff involved in this effort were already engaged in outreach work. Others, however, began the process with considerable discomfort making presentations in public. Almost

all of these staff worked hard to acquire these skills and feel proud of having gained competency in this area.

• The regional staff report was superbly supported by the State project office. Ms. Whitten, the Project Coordinator, was reported as being accessible, helpful, and encouraging. People in the regions felt they could always rely on her for whatever they needed that she could possibly provide.

• State staff took on and effectively handled a wide range of demanding tasks, which often required them to develop new competencies. Examples of the latter include management of contracts with consultants and vendors, preparation of newsletters and a video, and unraveling variations in the data found in the State and Federal systems. Staff had to, and did, maintain a delicate balance between working to ensure that the requirements of the grant were met (e.g. reports, number of outreach hours) and not being so intrusive and demanding that they alienated the regional staff.

• Last, but certainly not least, support at the State level from more senior officials was viewed as reflecting a broader commitment in the Agency to the work of the project. Ms. Kennedy and Ms. Donna Dedon were both mentioned on several occasions in our interviews as providing leadership and vision to the overall effort. Their efforts were particularly important in terms of administrative, procedural and systems changes that affected the simplicity and efficiency of eligibility, enrollment and re-enrollment operations.

Building on the experience of LACHIP

It would probably have been difficult to mount the MSP effort as quickly had Louisiana not already engaged actively in outreach and enrollment efforts for the LACHIP program. In many ways, as in a number of States, the SCHIP program called for, and elicited, a substantial change in the organizational culture of Medicaid agencies. This change had begun with the "delinking" of Medicaid from welfare programs. These changes led, in many States, to a shift in the role of Medicaid workers – from making sure that only eligible people were on the rolls to making sure that as many eligible people as possible were on the rolls. This is not to say that concerns about inappropriate enrollment went away, but it is to say that outreach to and enrollment of eligible people, particular vis-a-vis the CHIP program, began to be viewed as an inherent part of the State agency's job.

In Louisiana, the SCHIP program was operated by the State Medicaid agency. Ms. Kennedy took a leading role in the efforts to enroll children in this program and to ensure that the eligibility guidelines and enrollment process were administratively simple and sensible. The agency had also received a grant from The Robert Wood Johnson Foundation under its Covering Kids Initiative to get additional resources and support for LACHIP efforts. The work done on this initiative clearly set the stage for the work of MSP. Ironically, however, many of regional staff who engaged with the new work reported being pleased that the agency was balancing its focus on children with a focus on the elderly.

Supports made possible because of grant funding

Funding from The Robert Wood Johnson Foundation under the State Solutions program at the Rutgers Center for State Health Policy also provide several key supports to the work at the state and regional level. The following were identified as particularly critical by those we interviewed:

• The availability of paid overtime to attend events on the weekends and in the evenings; this was especially useful for regional staff who were trying to engage others who were not a part of their formal "team."

• The availability of promotional items of all kinds with the MSP logo, which could be used to create an interesting booth that attracted people at events.

• Expert consultants who provided training in doing focus groups with hard to reach populations and review of materials for appropriateness for low literacy people.

• Access to training and networking opportunities both for State staff at the national level and regional staff at the State level.

• Funding for a central staff to motivate and coordinate regional office efforts.

Support from partners

As noted earlier, regional office staff built useful partnerships with a substantial number and wide range of partners. Partners appear to have played a significant positive role in increasing both awareness of MSP in particular, and the trust of the target population in the program, and thus the Medicaid State Agency. State staff also built and maintained relationships with key Federal agencies, like Social Security, as well as key State agencies like the SHIP program. It is unlikely that significant increases in enrollment would have been possible without this network of partners. Key to the success of the partnering efforts was the fact that the relationship between the Medicaid agency and partners was so often highly reciprocal. Partners offered benefits and received benefits; as did Medicaid. This type of partnership is easiest to sustain over time.

Challenges and Barriers to Progress

Inconsistent managerial support across regions

In almost all cases, members of regional teams got the support they needed for the work from their managers. In a small number of cases, however, supervisors of individuals with responsibility for outreach were displeased when these individuals left the office to do this work. By and large, regional

team members worked around this barrier, but it may have prevented them from being as active in the field as they might otherwise have been.

Inconsistent performance across regions

There was substantial variation in performance across the nine regions of the State. Some regions were top performers from the outset and remained so. A few took a long time before they were actually meeting the minimum requirements with respect to hours of outreach, and lagged in their comparative performance all along. In a couple of regions, performance varied over time in one direction or another. It was difficult to identify, in this study, the reasons for this inconsistency in performance. It did not appear to be related to variations in the level the difficulty of reaching the target community.

One can speculate, based on general knowledge about organizational performance, on some possible factors that may have played a role. One is leadership; obviously a highly energized and creative leader would make a substantial difference in performance, and it is not surprising for there to be some variation in leadership capacity across units of any organization. The other factor, which is particularly relevant in public sector organizations, is that the "chain of command" for the project was relatively loose. The very autonomy that might well have energized some regions may have been a factor in not making the work of MSP outreach a significant priority in other regions.

The approach taken in response to this variation was sound, given the context. It was to give a lot of recognition to the high performers, both to keep their performance high and to subtly motivate others to do better. Nevertheless, if Louisiana is to achieve higher levels of enrollment in Medicare Savings Programs, it will need to achieve more consistent engagement and high performance across the regions.

Insufficient time to build state level partnerships

Partnership development at the local level was extremely good. However, Ms. Whitten expressed concern that she was not able to spend enough time (given her numerous other responsibilities), developing partnerships at the state-level with organizations that had local level units which could, in turn, partner with the Regional Teams. Frankly, we do not consider this barrier to be highly important; nothing in our interviews indicated that the regions had too few partners to do their work effectively.

Recommendations for the Future

The Louisiana State Solutions Project can be considered both a success and a model for other State Medicaid Agencies to follow in serving the needs of low-income people with Medicare. The work of enrolling this critical target population in Medicare Savings Programs is, however, far from done. Not everyone eligible has yet enrolled; over time, especially in the light of Hurricane Katrina, more citizens of Louisiana will become eligible for these programs. Indeed, given the fact that those enrolled in MSP will now automatically also receive prescription drug coverage under the new Part D of Medicare, the value of

these programs for eligible citizens, and indeed for all citizens, has grown significantly. The focus of our recommendations, therefore, is on what it is most critical for the Department of Health and Hospitals to sustain and enhance, going forward.

1. The central office of the Medicaid agency should reiterate that outreach and enrollment for MSP is and will remain a priority at both the State and regional level. There are at least two managerial strategies for supporting MSP as a priority. One would be to include performance on MSP as one criterion in the assessments of regional managers. Another would be to give recognition to regions and sub-regional units who were effective and/or creative in this work.

2. To the extent possible, regional teams should be maintained, and should continue to be supported by Regional Administrators and by directors of parish level units.

3. If at all possible, a "point person" for MSP outreach efforts should be identified at the State level. The absence of such a person was noted by many in the regions as a loss they feared would hamper their work. The major roles for this individual would be as an information and problem solving resource, and to continue to track and analyze patterns in outreach activities and enrollment.

4. The educational materials and promotional items developed with RWJF funding were much appreciated and effective. It would be helpful if such materials continued to be available to regional staff as they went about their work.

5. Regional office staff should maintain their strong working relationships with their current partners, and if possible continue to gradually increase the number of active partners. Note that virtually all those we spoke with believed firmly that these relationships would continue, since they have been so mutually beneficial.

6. If at all possible given budget constraints, funding should be made available for a certain number of hours of overtime for participating in outreach events on weekends and evenings. Again, the loss of this overtime was considered as potentially damaging by many we interviewed, especially with respect to regional team members whose family obligations would make it difficult for them to take on this kind of responsibility without some financial recompense. Funds for travel to outlying areas was also viewed as valuable, but most felt this would be available in regional budgets.

7. Continued emphasis should be placed on improving the simplicity and thus the efficiency of enrollment and renewal processes, as well as the information systems that support these processes. This is part and parcel of the process by which Louisiana is building a 21st century Medicaid agency.

APPENDIX A

INTERVIEW PROTOCOLS

REGIONAL COORDINATOR INTERVIEW GUIDE

MSP STATE SOLUTIONS STUDY

I. INTRODUCTION

Hello. My name is (insert) and I am part of a research team led by Professor Shoshanna Sofaer to learn about the strategies used by the State of Louisiana to increase the enrollment of low-income people with Medicare in the various Medicare Savings Programs. This interview is designed to get your perspective on the program, as it has been implemented in the (insert) region in the State. As we said in our email, please be assured that what you say today will stay strictly between you, me and Dr. Sofaer. We will be reporting on patterns and themes that we identify across all the regions, and although we use quotes in our report, the "quoter" will not be named. We hope this makes you feel free to be as candid, even as critical, as you would like.

Before we start, do you have any questions?

II. QUESTIONS

1. To begin, can you tell me how your role in the (insert) regional office in general?

2. What is your role in the MSP effort in your region? What are your responsibilities?

3. How did you come to have this role? *Probe – how much choice did s/he have about whether to participate? How if at all was this related to the other roles the person plays?*

4. From your personal and professional perspective, what do you see as a major benefit to working with the MSP effort? What if anything did you see as potentially problematic in serving (as regional coordinator/as part of the regional MSP team)?

5. Tell me about the region where you work.

a. What are the characteristics of the Medicare population here? What makes it hard to reach this population? What are the major "channels" to reach them?

b. Is it typical for people and organizations in this part of the state to work closely together or is it pretty rare? Why do you think that is so? *Probe on history; resources available; homogeneity of the community; shared concerns or values of the people who work with low-income groups*

6. Within your regional office, what access have you had to resources or support for your work on MSP? How do the rest of the regional office staff respond to the work you are doing on the program? *Probe on whether they really are given the freedom to spend 20% of their time on the program; probe how this fits with their other duties and responsibilities; probe on concerns about staff being out of the office rather than in the office; probe on fit between the program and the values and standard operating procedures of the regional office*

7. To whom do you see yourself as being "accountable" for what you do in this region vis a vis MSP? Why? *For those who are regional coordinators, probe re regional office v central office; for those who are not, probe on who whether there is any problem in terms of being supervised by different people for different aspects of their job*

8. Tell me about your relationship with the statewide program office. *Probe on the extent and quality of support they have gotten; respect for the knowledge and competency of statewide program staff; what demands are place on them by the statewide office; whether they feel they have enough autonomy and independence*

9. How, if at all, can your relationship with the statewide MSP office have been more productive? Why?

10. What aspect of that relationship do you think it is most critical to retain going forward, once external funding is no longer available?

11. Looking beyond the MSP program office, how much of a priority is this work within the State Medicaid agency overall? Compared to the past, has the priority risen? Do you expect this program to stay a high priority in the future? *Probe on what evidence they have re answers to these questions; probe also on the reasons something becomes a priority in the state agency overall*

12. Let's talk now about partnerships. How many partners do you have? Can you tell me who some of your partners are?

13. Do you have one "major" partner that you work with? Who is that? How and why did this group come to be your major partner? *Probe: What did they bring to the table? Who actually made the decision to focus on this group as the major partner?*

14. What were you looking for in selecting your partners? *Probe on skills, legitimacy, links to low-income people? People with Medicare?*

15. What if anything were you able to offer to your partners to gain their involvement? *Probe: What benefits did they see from working with you in this area? Was there anything they wanted or needed that you were not able to provide?*

16. Were there groups or organizations you approached to work with you who were not willing to participate? If so, why were they unwilling?

17. What role or roles do your partners play? How does this differ from your role? How is it the same? *Probe on what things they each do separately and what they do* jointly

18. How do decisions get made about exactly what kinds of things your partners do to support the MSP program? *Probe on extent of collaboration and who typically takes the lead*

19. How do you figure out whether what you are doing is working? Have there been situations where you have had to return to the drawing board and figure out an alternative approach? How have those gone?

20. What kinds of issues or problems, if any, have arisen between you and your partners? How were they handled? Have you stopped working with any partners and if so why?

21. Now let's talk about the actual work! How would you describe your outreach and enrollment strategy? *Get as many concrete details as possible here, with special emphasis on things the partner did and how they worked collaboratively*

22. How different was this approach for your regional office? How much of the approach do you think has become "standard operating procedures" in the office? *Probe on what has helped get things incorporated into standard practice and what makes it hard Probe also on whether this approach has had any influence on other aspects of the work of the regional office, such as outreach to families and children*

23. What was the most creative thing you did? The most difficult thing you pulled off?
What would you have most liked to do but couldn't?

24. So far, what have been the results? *Probe on numbers of people enrolled overall, numbers in various really hard to reach categories, other relationships built, skills and capacities built, etc.*

25. Would you have been able to do this without support from the state MSP office? Why or why not?
What have they provided that makes the biggest difference in your efforts?

26. Would you have been able to achieve these results without your partners? Why or why not?

27. Let's talk now about the future, especially once grant funding is over. What do you expect will happen to your own participation? To the rest of the team here in your region?

28. How will the end of grant funding affect the ability of the regional office to reach low-income people with Medicare? *Probe in particular on the ability of the regional office to deal with imminent challenges around MMA and drug coverage for low-income people and people with Medicaid*

29. How do you think grant funding will affect the participation of your partners? How do you expect your relationship with partners to change? To stay the same?

30. What is the single most important aspect of the MSP efforts, and your regional work, that should be sustained into the future? What will it take, do you think, to do that?

31. Is there anything else you think we should know about this experience?

Thanks so much for your time and your insights. They have been very helpful.

PARTNER INTERVIEW GUIDE

MSP STATE SOLUTIONS STUDY

I. INTRODUCTION

Hello. My name is (insert) and I am part of a research team led by Professor Shoshanna Sofaer that is trying to learn about the strategies used by the State of Louisiana to increase the enrollment of low-income people with Medicare in the various Medicare Savings Programs. As I understand it, you have partnered with the efforts of the State Medicaid program staff in the (insert) region in the State to support this important goal. As you know, we got your name from (insert name) from that regional office. We are interviewing you and other partners like you in different regions because we know it is important to get the perspective of people like yourself, as well as state staff, if we are to understand what has worked well, what could have been done better, and in particular what really needs to happen to maintain the efforts to date.

I want to assure you that what you say will stay strictly between you, me and Dr. Sofaer. We will be reporting on patterns and themes that we identify across all the regions, and although we use quotes in our report, the "quoter" will not be named. We hope this makes you feel free to be as candid, even as critical, as you would like. Before we start, do you have any questions?

II. QUESTIONS

1. To begin, can you tell me a little bit about your agency? What's your mission? Who are your clients? To what extent do you see your mission and your client group as overlapping with or different from that of the Louisiana Medicaid program?

2. How did your agency become involved in working on the MSP project? What made the agency want to get involved? Was there anything that made your agency concerned about getting involved? If so, what was that and how was it dealt with? *Probe on history of previous interactions, on whether impetus came from State or from their agency, on whether the state as opposed to the regional office was critical in building the partnership*

3. How would describe the role of your agency in increasing enrollment of low-income people with Medicare into the various savings programs? How is that role different from the role of the State? How is it the same? *Probe to identify special assets/resources they brought to the table and how those complemented those of the Medicaid agency.*

4. Could you provide one or two examples of how you work with the Medicaid folks around enrollment

of seniors and the disabled in savings programs? It would be great if these examples illustrated strategies that have proved especially effective in increasing awareness and enrollment. *Get as many concrete details as possible here, with special emphasis on things the partner did and how they worked collaboratively with the Medicaid office*

5. What kind of support have you received for your work in this area from Medicaid? *Probe on what they do for the partner?* Was there/is there support you could have used that you were not able to get? *Probe on whether they have shared this and how they feel that it is not there.*

6. How would you describe your overall role and responsibilities in your agency? What has been your role and your responsibilities vis a vis partnering with the MSP program? *Probe on how tightly linked normal duties are to partnering related duties.*

7. From your personal and professional perspective, what do you see as the major benefits to working with the MSP effort? What if anything did you see as potentially problematic in working as a partner with MSP?

8. From the perspective now of your organization, what do you think have been the major benefits in working with the MSP effort? What if anything do you think have been problems for the agency in working as a partner with MSP?

9. Let's talk now about the future, especially once grant funding from the Robert Wood Johnson Foundation for the MSP program ends. What do you expect will happen to your partnership with Medicaid on MSP? To your own role? What might be the consequences in any changes that ensue if grant resources are no longer available?

10. What is the single most important aspect of the MSP program, and your partnership with Medicaid, that should be sustained into the future? What will it take, do you think, to do that?

11. Is there anything else you think we should know about this experience?

Thanks so much for your time and your insights. They have been very helpful.

Endnotes

[1] Dr. Sofaer in turn retained the services of Erin Kenney, Ph.D... Dr. Kenney has worked closely with Dr. Sofaer for most of the last 20 years. She is expert in the Medicare program, in efforts to reach out to and educate people with Medicare, and in assessing efforts that involve public-private partnerships. She is also very expert in the research methods used in this work. Her role in the project was to conduct and summarize key informant interviews.

[2] The total for January 2001 includes 1,426 persons enrolled in the QI-2 program, which has since ended.