

## Facilitator Guide: Medicaid

### Learning Goals and Objectives

- 1. Build a basic understanding of the Medicaid program and its historical context.**
  - a. Describe the pertinent historical events which resulted in the development of the current structure of Medicaid.
  - b. Highlight trends in child health coverage over time, including proportion of children covered and costs of care.
  - c. Compare the US approach to providing child health coverage with that of other nations.
- 2. Describe the role Medicaid currently plays in providing access to care for US children.**
  - a. Explain federal and your state’s eligibility requirements to qualify for Medicaid.
  - b. Describe how Medicaid approaches unique populations: pregnant women, children with special healthcare needs, children in substitute care, and immigrants.
  - c. Compare and contrast private and public insurance coverage for children, and the role of EPSDT in structuring benefits.
  - d. Reflect on how differences in insurance coverage may contribute to health disparities in the US.
- 3. Construct a plan to advocate for health care coverage and access at the individual and system levels with a focus on Medicaid.**
  - a. Create a messaging framework for Medicaid, considering how the language used can reach the broadest audience.
  - b. Implement individual strategies to advocate for patient coverage/access in your county or state.
  - c. Propose systemic advocacy opportunities for Medicaid with your AAP chapter or AAP Federal Affairs.

This module is designed to help the learner develop a basic understanding of the Medicaid program and its role in providing access to care for children. The learner should be able to understand the historical context, the basic structure of Medicaid at the federal and state levels, and the coverage framework. Using this information, the learner is encouraged to identify opportunities to advocate for patient coverage and access via Medicaid.

**1. Pre-Work:** This consists of three websites for the learners to review briefly, focusing on how your state is faring in terms of Medicaid coverage. This is followed by a brief video which is 11 minutes in length; feel free to have them start at 4:38, which covers some basic history of Medicaid and the origin of the state to state variability. Finally, there is a list of common acronyms to review. This Pre-Work is designed to be completed by learners to prepare them for the in-class presentation/discussion. Facilitators should review the Pre-work document so as to be able to discuss the material with their learners at the onset of the presentation.

2. **Presentation:** The facilitator guide serves as a guide with background information for the presenter for the slides and the cases. It aims to tie together the ideas and materials in the clips and articles.
  - a. Introductory Slides: Provide background on key concepts.
  - b. Discussion Questions: Provide prompts for group discussion.
3. **Dig Deeper:** This section includes references and further resources for facilitators, learners or programs that would like to go further in depth into these topics.

### **Part 1: Build a basic understanding of the Medicaid program and its historical context.**

- Describe the pertinent historical events which resulted in the development of the current structure of Medicaid.
- Highlight trends in child health coverage over time, including proportion of children covered and costs of care.
- Compare the US approach to providing child health coverage with that of other nations.

#### **Outline:**

- **Plan for 20 minutes of slide presentation time**
- Review slides 1-8
- Discussion prompts
- Optional: Dig Deeper activity: Insurance coverage and health outcomes: A comparison of the U.S. to other industrialized countries

#### **Guideline:**

This section reviews the historical events that led to the creation of the Medicaid program, the evolution of Medicaid, and how Medicaid currently contributes to covering health care costs of Americans.

#### ***History of Medicaid (Slide 4)***

In the beginning of the 20<sup>th</sup> century, medical care was primarily symptom management and rarely curative as there were few diagnostic tests and treatments available. Doctor visits were paid for in cash or by barter and trade, and those unable to afford care either negotiated free or discounted prices from the local doctor, or went to charitable hospitals.

The intersection of several overarching events led to the creation of the Medicaid program:

1. Advancements in medicine. New treatments such as antibiotics, aseptic surgical techniques, dialysis, and transplants changed the role of the hospital from a dying place for the indigent, to high tech curative centers. This led to increasing health care costs, and hospitals found it difficult to ensure payment for services. Hospitals started offering hospital-only coverage plans to teachers, which led to the beginning of Blue Cross. For those who are interested in learning more about the origins of health insurance in the U.S., see <https://www.npr.org/templates/story/story.php?storyId=114045132>
2. Rise of employer-based private insurance. After the industrial revolution, many states enacted worker's compensation plans to cover workplace injuries. Employers found it

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cheaper to contract with certain physicians for these services. Labor unions began to advocate for inclusion of more comprehensive health insurance in their contracts. This resulted in only able-bodied working adults having access to health insurance, leaving the elderly, disabled, homemakers, and children without coverage.

3. The Great Depression. With high poverty rates and rising healthcare costs, the impact of rising health care costs were being borne by charity organizations and state funds. States were spending a larger proportion of their welfare funds on health care, and requested permission to use federal welfare funds on medical assistance.

### *History of Medicaid (Slide 5)*

Title XIX of the Social Security Act was signed into law by Lyndon B. Johnson in 1965, establishing the Medicare and Medicaid programs. The original Medicaid program only covered hospital care (inpatient and outpatient), physician services, lab, xray, and skilled nursing. It was an *optional* program for states, and states would receive between 50-83% federal matching funds for participation. Mandatory coverage groups at the time included only those receiving cash assistance such as the blind, disabled, and recipients of Aid to Families with Dependent Children (now called TANF). All other populations as well as benefits such as outpatient primary care, physical therapy, prescription drugs, and home health, were optional at the states' discretion. To learn more about the legislative history of Medicaid, see <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194918/>

- *Fun fact:* Arizona was the last state to opt into the Medicaid program, in 1982. At that time, Arizona's Medicaid coverage only included acute hospital care.

### *Evolution of Medicaid coverage (Slide 6)*

Since Medicaid was established, the program has played an increasingly important role in coverage of children. Through a series of expansions to include youth age 19-20, children with disabilities, and low-income pregnant women and children not receiving welfare, as well as the contributions of the Children's Health Insurance Program which was established in 1997, Medicaid now covers 40% of all U.S. children. Services covered by Medicaid have also increased; in 1967 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services were mandated (see Dig Deeper slides for more on EPSDT), and in 1989 Federally Qualified Health Center (FQHC) services were also added. For a detailed timeline on Medicaid key developments, see <https://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicaid-timeline.pdf>

- *Discussion option:* The uninsured rate for children is at a historic low. However 2/3 of children without insurance are eligible for Medicaid or CHIP, but not enrolled. Why is this the case, and what could we do to get them enrolled?
  - Lack of knowledge about the program and whether they are eligible
  - Fear that using Medicaid will hurt chances of getting citizenship/green card
  - Difficulty with enrollment – low literacy, primary language non-English, low education, unstable housing making it difficult to maintain requirements for frequent renewal paperwork
  - Children are healthy so not sure why they need insurance
- *Dig Deeper:* The Affordable Care Act gave states the option to expand Medicaid to non-disabled adults. How does increased coverage of parents affect health of

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children? <https://ccf.georgetown.edu/2018/01/12/research-update-how-medicaid-coverage-for-parents-benefits-children/>

- Children were more likely to be enrolled if their parents were enrolled
- Children whose parents were more likely to have had a well child visit
- Healthy parents are better equipped to care for their children
- Insured parents means less out of pocket money spent on health care, leaving more for other things i.e. food, housing

### ***Medicaid and Spending (Slide 7)***

The U.S. spent \$565.5 billion on Medicaid and \$671.2 billion on Medicare in 2016. Although children comprise 43% of Medicaid recipients, they account for only 19% of Medicaid expenditures. The average Medicaid expenditure per non-disabled enrollee in 2014 was \$3,955 for adults and \$2,602 for children. The top 1% of patients utilize 21% of healthcare dollars, and the top 5% account for more than half of spending. For more on national health expenditures and where the U.S. spends its healthcare dollars, see <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

### ***Comparison to other health systems (Slide 8)***

Health coverage in the U.S. evolved into the current system of employer-based private coverage, and public coverage for the low-income and disabled. Other countries have developed different strategies, and most have some form of universal or near-universal coverage. The U.S. stands out amongst Organization of Economic Co-operation and Development (OECD) nations as the one with the highest uninsured rate and lowest proportion of public coverage. We spent an average of \$10,348 in 2016 per person on health care (including public, private, and out of pocket sources), roughly twice the amount of other comparable industrialized countries. However, our access to care and health outcomes are not better. Americans report more problems with access to care, and also have lower life expectancy and higher infant mortality than other countries.

- *Dig Deeper:* See Dig Deeper Slide 26. Use the following resources to complete the table comparing health care spending and health outcomes between countries. How does the U.S. compare? What can we learn from other systems?
  - [https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/?\\_sft\\_category=quality-of-care#item-adults-comparable-countries-quicker-access-doctor-nurse-need-care](https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/?_sft_category=quality-of-care#item-adults-comparable-countries-quicker-access-doctor-nurse-need-care)
  - <https://data.worldbank.org/indicator/SH.XPD.OOPC.ZS?end=2014&locations=US&start=2014&view=map>
  - [http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755\\_davis\\_mirror\\_mirror\\_2014.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf)

### Part 2: The role Medicaid currently plays in providing access to care for children

- Explain federal and states' eligibility requirements to qualify for Medicaid.
- Describe how Medicaid approaches unique populations: pregnant women, children with special healthcare needs, children in substitute care, and immigrants.
- Compare and contrast private and public insurance coverage for children, and the role of EPSDT in structuring benefits.
- Reflect on how differences in insurance coverage may contribute to health disparities in the US.

#### Outline:

- Plan for 20 minutes of slide presentation time
- Present slides 9-18
- Engage learners in an activity about how Medicaid requirements differ in different states
- Provide learners with a vocabulary to discuss Medicaid components and requirements
- Help learners reflect on about how insurance coverage may impact patient care they provide

#### Guidelines:

In this section, we are going to look deeper at what is presently happening with Medicaid in the US, why there is variability in coverage by state, and how this may affect care that is provided.

#### *Medicaid Coverage Across the US (Slide 10)*

The percent of children covered by Medicaid varies widely across the US. In some Congressional Districts, as few as 9% of children are covered by Medicaid whereas in other areas as many as 68% of children covered. (See Medicaid coverage map at: <https://ccf.georgetown.edu/map/2016-children-congressional/>)

- Discussion Option: You may ask learners to give thoughts about why there is so much variability. *Possible points to consider:*
  - Children who are eligible but not enrolled
  - Variation in eligibility requirements by state
  - Variation in rates of child poverty by region/state/county (Graphic available in *Dig Deeper*)

#### *How Medicaid is Funded (Slide 11)*

Medicaid is funded by both the federal government and state governments. The federal government guarantees matching funds to states for **qualifying** Medicaid expenditures. The matching rate varies from state to state based on economic conditions within the state (**See dig deeper: FMAP**) This agreement allows federal funds to flow to states based on actual costs and needs as economic circumstances change. States must ensure they can fund their share of Medicaid expenditures. There are currently no caps to this funding for eligible services. Recent legislation has aimed at changing this arrangement by instead giving states a lump sum of money (block granting) and placing caps on funds, but this legislation has not been successful due to the heavy dependence of states on the matching funds. States are allowed, and some do, provide services beyond what is considered qualifying services by the federal government and they

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generally fund this themselves or through other various strategies that you can explore in the dig deeper for your own states.

Please note: You may want to remind learners that they heard about this and the information presented in the next slide in the video they watched for pre-work.

### *Variability of Medicaid Coverage (Slide 12)*

Because of how Medicaid is funded, each state establishes their own rules regarding eligibility, benefit packages, and provider payment policies. The federal government dictates certain baseline requirements, but each state essentially runs its own program with a wide range of variability across states such that qualifying for Medicaid in 1 state, does not guarantee you coverage in another state. For example, let's say a pregnant woman and her husband, who together earn 125% of the federal poverty limit move from New Mexico to Texas with their 3yr child. In NM, all 3 of them would be covered by Medicaid, but in TX the husband would lose his coverage.

Despite this variability, there are certain **low-income** populations that are historically covered nationwide including children under 18 and their parents, pregnant women, seniors over 65, and people with disabilities.

### *Medicaid for Unique Populations (Slide 13)*

There are also certain populations that garner additional benefits and others that engender additional restrictions to coverage. Because this varies greatly by state, it is important that learners are aware that these populations exist and know where to find information about specific coverage by state. Some of the unique populations that fall into that category are pregnant women, children with special healthcare needs, children in substitute care (such as foster care and incarcerated youth) and immigrants. For example, although federal law requires that pregnant women up to 133% of FPL are covered by Medicaid while they are pregnant and 60 days postpartum, the income cut off for coverage, range of services covered and length of time that coverage lasts, varies by state. Eligibility for Medicaid also varies significantly between different legal categories of immigration. It is important to note that undocumented immigrants are NOT eligible for federal Medicaid dollars in any state. However, some states secure other funding to cover these individuals under the general auspices of their state Medicaid program.

### *Webquest Activity (Slide 14)*

- *Discussion Option:* Have participants fill out the web quest table “Medicaid Eligibility Web Quest” using the links on the slide and from the prework. You can print out WebQuest activity at the end of this Facilitator Guide. Part A and Part B are recommended, with additional activities in the Dig Deeper section if your timing allows. If you are particularly constrained for time, have your learners complete Part A or Part B. You may want to ask if your learners discovered anything new from completing this activity. You may also ask if anything that they learned during the activity surprised them.

### *What Medicaid Actually Covers (Slide 15)*

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It is important to recognize that even if someone qualifies for Medicaid not all services are covered. Some services are mandated (i.e. Early and Periodic Screening Diagnostic and Treatment [EPSDT], In-patient and out-patient hospital services, Laboratory and X-ray services, Nursing facilities, Birth Centers, Home health services, Family Planning, Physician, Midwife and NP services, Rural health clinics, FQHC services, Transportation to medical care, and tobacco cessation for pregnant women) but others are not such as hospice, prescription drugs, PT, OT, speech, and eyeglasses. One key thing to know is that EPSDT provides comprehensive and preventive health care services for children under age 21 (basically the well child visit care) who are enrolled in Medicaid.

A few definitions for facilitator's reference:

- EPSDT stands for Early Periodic Screening Diagnostic and Treatment: this includes Mental, dental, developmental screening, vision, hearing –more on this program in the Dig Deeper section.
- Birth Centers are facilities for labor and childbirth that are often separate from hospitals, although they can be integrated within hospitals. Deliveries at birth centers are often overseen by midwives.
- FQHC: Federally qualified health center
- *Discussion Options:* You may ask learners whether there are any things that surprise them on either list. (eg. That prescription drug coverage is not mandatory, NP's but not PA's mandated to be covered etc)

### ***Medicaid Advantages and Challenges (Slide 16 and 17)***

There are both strengths and areas for improvement in Medicaid. Some of the “Pros” include that Medicaid provides services at a lower cost. Medicaid often has more benefits than many private plans due to the requirements, and without cost sharing for patients. This includes things such as PT, OT, Speech, DME and mental health services, making it especially important for children with special health care needs. Another major strength is that covered mandatory benefits cannot be changed without changing the law. In this way, Medicaid serves as a double safety net. It provides coverage for the poor and potential coverage for the very sick when they hit lifetime maximums, loss insurance, or benefits change. Medicaid is considered cost efficient with less per capita expenditures even when taking into account the fact that the benefits it offers are more robust.

One of the main challenges of Medicaid for patients is that overall it is accepted at lower rates than private insurance, although there is wide state-to-state variation in this with some states having higher rates of acceptance than private insurance and other states having much lower rates of acceptance. This can reduce access for patients not only to physician providers, but to other health services such as rehab services, home health, etc.

A study of pediatric primary care providers published in *Pediatrics* in 2002 demonstrated the top three factors influencing whether or not they accept Medicaid patients are reimbursement, capitated payments (vs. fee for service), and paperwork burden. (Increased reimbursement is associated with increased acceptance, whereas increased capitation and paperwork are associated with lower rates of acceptance of Medicaid patients.) A subsequent paper in 2017 (Tang) showed when Medicaid payment increased office based primary care saw an increase in Medicaid participation.

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- *Discussion Options:* (Slide 18)
- Involve the learners in a reflection activity by breaking them into pairs for sharing. You can ask them to consider one of 2 scenarios. For option A, you can ask them to consider when they had difficulty providing care to a child related to insurance coverage. You can ask them to discuss this further by asking how this impacted the care they provided and what barriers they overcame in order to provide care to this patient. Additional probes include: Consider examples from an exposure during medical school or residency Describe the barrier. Was it a disparity between Medicaid coverage and private coverage? Was it a disparity between Medicaid coverage in two states in close proximity? Was it a disparity for a required ESPDT benefit? How has this scenario impacted your subsequent or future patient care encounters?
- For option B, you can ask them to discuss what coverage challenges they face regarding their entire patient population. For this option, learners will need to have perspective from a longitudinal experience in which they have exposure to challenges across a patient population, eg. continuity clinic. Additional probes include: consider reimbursement rates for visit types, vaccination delivery, and Applied Behavioral Analysis (ABA) therapy. How does reimbursement impact the patients that are able to obtain care within your clinical setting?

### **Part 3: Medicaid Advocacy in Action**

Objectives Covered:

- Create a messaging framework for Medicaid, considering how the language used can reach the broadest audience.
- Implement individual strategies to advocate for patient coverage/access in your county or state.
- Propose systemic advocacy opportunities for Medicaid with your AAP chapter or AAP Federal Affairs.

Facilitator’s Role: For this part of the module, your role is to help develop activated, passionate champions for Medicaid by exploring concrete strategies and steps for engaging in advocacy.

Outline:

- Timeline: Plan for 20 minutes to include the slides and the activities in this section
- Present slides 19-29
- Explore opportunities and mediums to advocate for Medicaid and examine examples of Medicaid advocacy
- Identify effective components of an advocacy message and provide learners with concrete tools to construct an advocacy message
- Create an advocacy message that learners can use in their own community

Guidelines: In this section, we will develop strategies to advocate for coverage and access for children, with a focus on Medicaid and using examples created by pediatricians. Start by reviewing the objectives on slide 19.

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### *Case Study (Slide 20)*

Learners were asked to read this op-ed as pre-work. You can also have learners pull it up on their mobile device and read it during the session – it is short and will take only a few minutes to read. You may want to bring paper copies of it as well depending on your learning setting.

Valerie Borum Smith, MD. Cuts to Medicaid Would Badly Damage Health Care in Rural Texas. The Dallas Morning News. 2017.

Available online: <https://www.dallasnews.com/opinion/commentary/2017/06/12/cuts-medicaid-badly-damage-health-care-rural-texas>.

*Discussion:* Ask one person to summarize the op-ed. Make sure to mention that it was written by a pediatrician who sees children covered by Medicaid and how we can use our experiences as content for advocacy messages. As you begin the discussion, it is also helpful to emphasize that there are no right or wrong answers. The intent is to generate discussion, particularly focusing on how a pediatrician can most effectively use their voice.

What was effective about the op-ed? [Some ideas: Utilized a patient story with details, included data from trusted sources, described the importance of Medicaid for the local community, depicted how Medicaid cuts could affect people in that state.]

What could make the message even more powerful? [Perhaps include a quote from the child or child’s mom, with their permission, about what Medicaid cuts would mean to them.]

### *The Pediatrician’s Voice (Slide 21)*

Many of you may have heard Dr. Hanna-Attisha, seen here, as she used her voice as a pediatrician to raise awareness about rapidly rising lead levels in the water in Flint Michigan. Pediatricians are uniquely positioned to make a difference. We are credible because we bring data and are aware of problems that patients face. We have consistent contact with young children disenfranchised by society and their families/caregivers. We bear witness to the struggles of our families. Even as a trainee, your voice is important because it carries respect and a standard of professionalism.

Discussion Option: (You can do this if you have time, otherwise go to next slide) Ask the group for additional ideas about how the pediatrician’s voice is unique and the value of the pediatrician’s voice in the public sphere. [Some ideas: public trust in pediatricians is high, families of all backgrounds place high levels of trust in pediatricians, trainees are the current and future medical workforce so their voice is especially important.]

### *Crafting a Message – (Key Elements Slide 23)*

The key elements for crafting an effective advocacy message, as seen here in an introduction to testimony being given in Texas, are addressed in Module #4. (Taking Action to Address Child Poverty), but we will be providing a brief overview to ensure a shared understanding. Read through the list on the slide.

Discussion: How are these elements applied in the pre-work readings? Emphasize that the advocate does not have to go it alone! Institutions and chapters may have people/resources to help support the creation of an advocacy message – for example, if you are providing legislative testimony and speaking on behalf of an institution, you may have help in writing the testimony from a government affairs expert at your institution. In addition, you can look at the AAP

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Federal Affairs webpage to look at language the AAP uses for critical issues, such as health care coverage. You can use this language in your testimony, op-ed or other message you are creating. In addition, you can identify a colleague who is an active advocate and get their help in drafting a message.

**Dig Deeper:** You can have learners look at this toolkit and this example of testimony for further discussion.

The National Consumer Voice for Quality Long-Term Care. Advocacy Toolkit: Crafting and Effective Advocacy Message. 2017. Available online: <http://theconsumervoice.org/issues/for-advocates/advocacy-toolkit>.

Texas Pediatric Society and Texas Medical Association. Testimony of Ryan Van Ramshorst, MD to the House Public Health Committee: HB 839: Relating to Presumptive Eligibility for the Medicaid and Child Health Plan Programs for Certain Children. 2015. Available online: <https://txpeds.org/2015-legislative-session>.

### ***Group Activity – A Medicaid Message (Slide 23)***

For this slide, you should provide Medicaid fact sheets from which learners can pull some statistics. <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Medicaid-Fact-Sheets.aspx>. This is designed to be an interactive group activity; depending on group size you can ask the group to do it together or do it in smaller groups. Keep this exercise to 3-5 minutes as the goal is to help learners think through the process, not to develop the perfect message. Let learners know they will build upon this later in the talk.

Now we will put these elements into practice. At the end of this session, you'll have the framework for an advocacy message that you can utilize. Let's start by framing the issue, identifying some relevant facts or statistics, and thinking of a patient story.

**Discussion:** Give examples of the broad categories to identify an issue for this framing exercise (for example: protect Medicaid, prevent changes to financing, work to improve Medicaid).

Current events may guide what types of examples you suggest. Write a few bullet points about a patient that illustrates the importance of the issue. Remember to include details to help the audience create a mental image of the child/family. If they have difficulty coming up with patient stories, this is an opportunity to suggest that they start keeping a journal or Word document as they see patients whose stories could be helpful for advocacy messages in the future. This list should have enough detail for them to recall in the future who the patient was, but should be de-identified to follow HIPAA rules

### ***Advocacy in Action – what can you do? (Slide 24)***

Where can you take your message? As an individual you can post on social media, including Twitter and Facebook. We'll look at examples tweets in the next slide. Other, newer forms of social media like Instagram, Snapchat, and others are less often used by legislators. You can submit to print/online media, such as letters to the editor, op-eds, or blogs. And you can certainly educate those around you, in continuity clinic, grand rounds, and community forums. Many practices offer support to families to enroll in Medicaid or CHIP, using a financial coordinator, social worker, or case manager to give families information about how to apply. Or, collaborate with or refer to those who can help families determine eligibility and enroll, such as

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community based organizations (e.g. food bank, faith-based institutions, children’s advocacy groups).

There are many more avenues for advocacy, and these may change over time. What is most important is for you to think about what you are passionate about, how you best communicate, and what opportunities you have access to.

### *How did they do? (Slide 25)*

For this slide, it is best to have internet access so you can use the hyperlinks.

Here are a couple of examples of tweets advocating for Medicaid. (If there is time, click on Dr. Costello’s tweet to quickly scroll through the whole thread).

Discussion: What makes these tweets effective? (Some ideas: Richard Pan - Included an action (phone # to call); tagged trending topics (Graham-Cassidy Bill, Don’t Cap My Care); linked to his Facebook page that has more information including an AMA article. Lisa Costello – Tagged her senators in West VA; tagged trending topics (Graham-Cassidy Bill, Don’t Cap My Care); included a photo (known to increase clicks in Twitter); the tweet is actually a thread of 10 tweets that share her own personal perspective, how Medicaid helps her patients, state-specific stats (click to see full thread). Ask for suggestions for improvement.

### *Pair/Share Activity- Advocacy in Action (Slide 26)*

Keep this activity to 2-3 minutes of crafting the message, as goal is to practice, not achieve perfection. **If time is short, could ask learners to save this activity for a “Dig Deeper” and skip to next slide.** With extra time, ask one or two pairs to share what they wrote.

Now you’ll put your message framework into action.

Examples of advocacy “targets” include: elected officials, hospital administrators, or thought influencers (such as journalists or activists). Choose whether to turn your message (issue + facts + patient story) into a tweet or a short elevator speech.

### *Advocating for System Change (Slide 27)*

Before reviewing this slide, consider familiarizing yourself with the current “hot topics” regarding Medicaid from the websites referred to on the slide and be prepared to discuss one or two, time permitting.

We’ve gone through what you can do as an individual. When it comes to system change, it is critical to work with partners. Some examples of system change could include advocating against work requirements for Medicaid, expanding the Medicaid formulary, or improving physician payment.

First, familiarize yourself with websites like the Kaiser Family Foundation, the Georgetown Center for Children and Families, and the Annie E. Casey Foundation. These websites are up-to-date with the latest evolving issues in Medicaid. Then, think through these issues, how they affect your patients, and what changes need to happen to protect or expand child health coverage. Lastly, you may decide to partner with your local AAP chapter, the AAP Department of Federal Affairs, your institution, or others. The AAP has a history of partnering with many other professional groups, such as the Children’s Hospital Association, the American Congress of Obstetrics and Gynecology and the March of Dimes.

Additional examples of systems issues include (more detail can be found in the links in the slide) Transition to Medicaid managed care

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Insurance network adequacy

Medicaid waivers (e.g. 1115 waiver)

Implementation of cost-sharing (e.g. copayments, premiums)

### *Ready to Try It on Your Own? Advocacy Dos and Don'ts (Slide 28)*

Briefly read through the list on this slide.

Being honest may mean admitting that you don't have all of the information, which is OK! It may help to say, "I'm not sure, but I will get that information to you" rather than losing your credibility by making something up.

Individual institutions have varying policies regarding engaging in advocacy activities on behalf of the institution (e.g., using the institution's name in communications), and that it is always better to err on the safe side and keep the institution informed. Therefore, before participating in advocacy activities, people should get explicit permission from their institution's corporate media relations office and/or government affairs office, or have a previously discussed agreement with them. Unless they are functioning as a representative of the institution, people should not use institutional time or resources for advocacy activities they are engaging in as a private citizen. Non-profits are also required to report any lobbying activities, so should be aware for that reason as well.

Discussion: If there is time, you can ask learners to share any experiences they may have already had with advocacy and what worked well and what some challenges were.

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### **Dig Deeper activities:**

#### **Parts 1 and 2:**

<https://ccf.georgetown.edu/map/2016-children-congressional/>

"Where are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults" KFF March 2017

<https://www.medicaid.gov/medicaid/by-state/by-state.html>

<https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>

<https://ccf.georgetown.edu/state-childrens-health-facts/>

<https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html>

<https://www.kff.org/medicaid/fact-sheet/early-and-periodic-screening-diagnostic-and-treatment/>

<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

<https://www.kff.org/medicaid/issue-brief/medicaid-spending-growth-compared-to-other-payers-a-look-at-the-evidence/>

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.4.w318>

<https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>

Berman et al. Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients. *Pediatrics*, 2012; 110 (2):240-248.

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### Part 3:

Valerie Borum Smith, MD. Cuts to Medicaid Would Badly Damage Health Care in Rural Texas. The Dallas Morning News. 2017. Available online:

<https://www.dallasnews.com/opinion/commentary/2017/06/12/cuts-medicaid-badly-damage-health-care-rural-texas>.

The National Consumer Voice for Quality Long-Term Care. Advocacy Toolkit: Crafting and Effective Advocacy Message. 2017. Available online: <http://theconsumervoice.org/issues/for-advocates/advocacy-toolkit>.

Texas Pediatric Society and Texas Medical Association. Testimony of Ryan Van Ramshorst, MD to the House Public Health Committee: HB 839: Relating to Presumptive Eligibility for the Medicaid and Child Health Plan Programs for Certain Children. 2015. Available online: <https://txpeds.org/2015-legislative-session>.

AAP State Medicaid Fact Sheets: <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Medicaid-Fact-Sheets.aspx>

AAP Federal Affairs: <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Federal-Advocacy.aspx>

AAP U.S. Child Poverty Curriculum: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/CPTI/Pages/U-S-Child-Poverty-Curriculum.aspx>

Kaiser Family Foundation: <https://www.kff.org/medicaid>

Georgetown Center for Children and Families: <https://ccf.georgetown.edu/topic/medicaid>

Annie E. Casey Foundation: [www.aecf.org](http://www.aecf.org)

## APA Poverty Task Force – Poverty Curriculum - Medicaid

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### Medicaid Eligibility Web Quest

#### Part A

Find the income eligibility levels (in terms of %FPL) for the following individuals to qualify for Medicaid or CHIP in your state:

	Medicaid	CHIP
Child 0-1		
Child 1-5		
Child 6-18		
Pregnant women		“Unborn Child”* model Y/N?
Adult with dependent children		
Adults without dependent children		

\*In some states, CHIP is used to cover pregnant women, either through full participation in the CHIP program or a more limited coverage which covers only pregnancy related issues under the auspices of covering the unborn child.

#### Part B

What forms of federal/state coverage are available to the following individuals in your state? (Options include Medicaid, CHIP, Perinatal CHIP, ACA marketplace, none.)

If applicable, what local/county programs are in place to fill coverage gaps?

	Coverage available (include any restrictions)
<b>Undocumented Immigrants</b>	
Children	
Pregnant women	
Other Adults	
<b>Qualified non-citizens</b>	
Children	
Pregnant women	
Other Adults	