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## Simplifying Medicaid Processes Can Increase Efficiency and Improve the User Experience

Rhonda Rogombé | Health and Safety Net Policy Analyst

### Introduction

Medicaid is a critical economic and health program in West Virginia, serving over 616,000 people, including children, seniors, low-income adults, pregnant and postpartum women, persons with disabilities, and more.<sup>1</sup> In addition to being the main source of health access for over one-third of the state's population, Medicaid covers the majority of births and more than three-fourths of long-term care, is the primary health insurance for over 50 percent of children, and provides substance use treatment and a range of other services in West Virginia, ensuring access to health care for our most vulnerable populations.<sup>2</sup> Medicaid's flexibility and reach has never been more clear than during the pandemic recession, when it provided health coverage for tens of thousands of West Virginians who lost other health coverage. Nevertheless, Medicaid and those who rely on it are often faced with stigmatizing language, mountains of bureaucratic hurdles, and harmful policy proposals.

Over the last year and a half, the West Virginia Center on Budget and Policy (WVCBP) has worked in partnership with West Virginians for Affordable Health Care (WVAHC) on a listening project to identify ways to enhance the Medicaid experience for West Virginians. Over the course of this project, our team has learned more about the Medicaid process through the experiences of those who utilize and administer the program, including state officials and legislators, health care providers and advocates, and — most importantly — Medicaid enrollees and people who are eligible but not enrolled in the program.

During this project, the WVCBP and WVAHC teams interviewed a combined 25 people categorized as either Medicaid stakeholders or people with lived Medicaid experience. These interactions led to the identification of several patterns critical to understanding the role of Medicaid in the Mountain State, and how it can better serve enrollees. While the project is ongoing, our preliminary findings can help stakeholders and policymakers craft policy priorities that can critically improve Medicaid's efficacy.

This brief will outline several policy recommendations derived from the project that can address our findings and improve the Medicaid program and health outcomes overall.

### Key Findings

- While Medicaid covers over one-third of West Virginia residents and has wide-ranging positive impacts on our state's economy, stigmatization of the program and its recipients remains prevalent.
- Overall, the largest barriers to accessing Medicaid indicated by respondents were lack of internet access and difficulty reaching Department of Health and Human Resources (DHHR) staff by phone.
- West Virginia is one of just four states in which a Medicaid application cannot be fully completed online in a single setting.
- West Virginia is one of just nine states that fails to offer telephonic signatures for renewal applications, thus increasing paperwork for Medicaid recipients and DHHR staff because renewals cannot be fully completed over the phone.
- Streamlining of Medicaid enrollment and renewal processes can save time and reduce workload for DHHR staff, particularly as the COVID-19 public health emergency ends and increases administrative workload.

<sup>1</sup> Department of Health and Human Resources Bureau for Children and Families Secretary's Report, March 2022.

<sup>2</sup> Rogombé, Rhonda, "Medicaid in the Mountain State: A Health and Economic Necessity," (Charleston, WV: West Virginia Center on Budget and Policy, July 2021).

## Methods

Throughout the listening project, the WVCBP and WVAHC utilized several methods to better understand the West Virginia Medicaid program. These methods included surveys, formal interviews, informal conversations, and discussions with state officials, health care providers, policy experts, advocates, and — most pertinently — people with lived Medicaid experience (PLME).

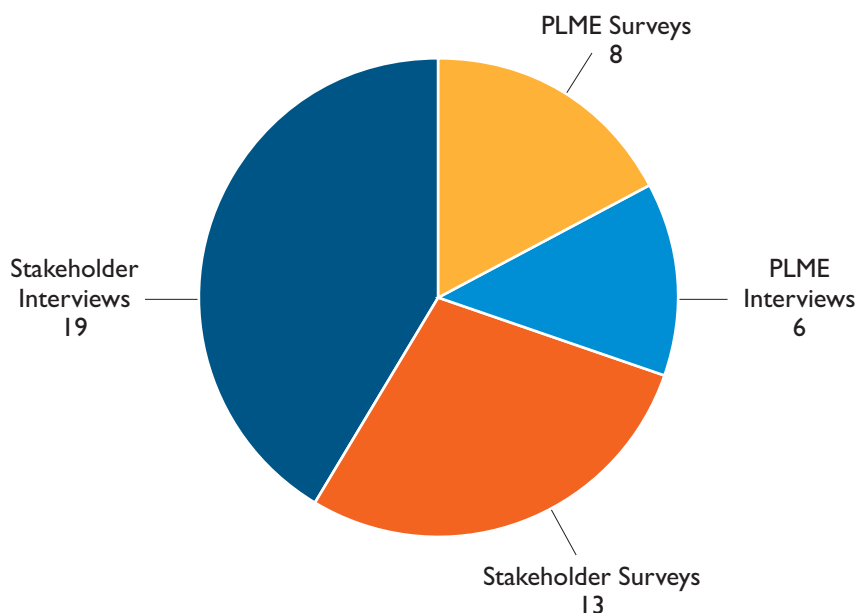
We synthesized the narratives we gathered throughout this period with quantitative data from various sources, including the Department of Health and Human Resources (DHHR), the US Census Bureau, and others. These quantitative sources initially helped identify some patterns as we began modeling this project; later, they served to further evidence the circumstances that the interviewees described. While this brief focuses on the qualitative and narrative data, relying upon a range of methods, backgrounds, experiences, and types of data allows us to begin to paint a holistic image of the Medicaid program in West Virginia.

This image includes how the program serves its recipients and has made a meaningful difference in their health outcomes. The expansion of health care services, such as postpartum care and dental benefits, are just a few examples of how West Virginia policymakers have utilized Medicaid's structure and flexibilities to serve the specific needs of West Virginians. Our research also led to the identification of ways in which the program could further utilize federal flexibilities to serve Medicaid-eligible people and enrollees more seamlessly. These findings included broad barriers not specific to Medicaid, such as unreliable transportation and negative attitudes toward the program. These are realities that all West Virginians — including policymakers — must acknowledge and address to best promote health across the state.

We separated our experts into two categories: Medicaid stakeholders and people with lived Medicaid experience (PLME). Medicaid stakeholders include health care providers, researchers, state officials, and other advocates; these individuals' expertise in health care relies primarily on their professional experiences. PLME consist of individuals and families with lived Medicaid experiences over the past several years, including experience navigating program application, enrollment, and renewal processes. Those who are Medicaid-eligible but did not receive coverage are also included in this group. These peoples' expertise primarily derives from direct lived experience with receiving or attempting to receive Medicaid coverage. While there is overlap between these categories — which enriches West Virginia's grassroots advocacy networks — our goal was to ensure that we tracked and centered those with lived experiences, both within and beyond the scope of the listening project. **Figure 1** breaks down the numbers of surveys and interviews from each group.

FIGURE 1

### Project Solicited Input from Range of West Virginians for Holistic View of Medicaid Surveys and interviews from stakeholders and people with lived Medicaid experience (PLME), 2021



Source: WVCBP analysis

Among our first and clearest findings was that PLME were more hesitant to share their experiences than stakeholders, both via survey and interview. Stakeholders — unlike many PLME — were quickly identified and readily available to share their experiences. Indeed, of the eight surveys we received from PLME, half were anonymous, and over 60 percent declined a follow-up interview. Conversely, all the stakeholders surveyed shared their names and contact information, and over half indicated that they were open to follow-up interviews.

Despite surveys being a traditionally strong quantitative tool — including in earlier phases of the listening project — the discrepancy between stakeholder and PLME surveys implied that other methods might be more appealing to the populations we were attempting to reach and thus better suited to serve the goals of this project. We identified the survey as a barrier within our intake process and replaced it with a streamlined form that helped increase overall engagement from PLME.

## Patterns Observed and Lessons Learned

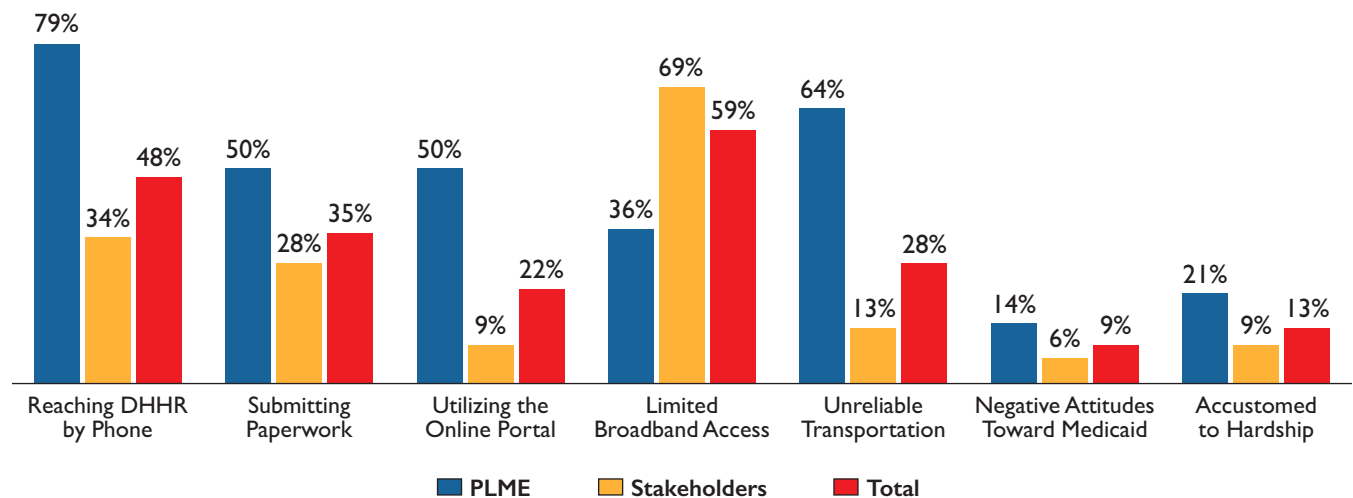
The overall response from both groups — stakeholders and PLME — underscored the critical role that Medicaid plays in providing access to necessary health care. Medicaid is the health insurer of one in three West Virginians. It covers half of births, health coverage for over 50 percent of children, and 76 percent of long-term care costs.<sup>3</sup> Those we talked to indicated its importance to obtaining necessary care, such as primary care, dental care, and other types of care in the broad range of services that Medicaid gives them access to. In general, once people have successfully enrolled in Medicaid, they tend to rate their experiences positively. National data suggests that most Americans have had some interaction with Medicaid (whether direct or indirect), view it favorably, and believe it is a valuable tool for connecting people to critical care.<sup>4</sup> We captured these attitudes in our correspondence with participants. Despite these responses, stakeholders and PLME alike indicated several patterns that negatively impacted peoples’ overall health care experiences, many of which prevented access to the program. These patterns fell into several broad categories, which we refer to as “process,” “socioeconomic,” and “cultural” barriers, respectively.

Process barriers refer to those barriers directly related to Medicaid’s application and renewal processes, like difficulty reaching a caseworker, submitting paperwork, or navigating the online portal. Socioeconomic barriers are not specific to the Medicaid program but still impact engagement, such as limited broadband access or unreliable transportation. Finally, cultural barriers involve features such as stigma (whether from PLME, their community, or agency employees) and generally negative attitudes toward Medicaid. By dividing them into these groups — which are by no means exhaustive or discrete — we hope to generate meaningful policy discussions that can appropriately address health care needs in our state in both the short-and long-terms.

**Figure 2** illustrates the barriers we were able to quantify.

FIGURE 2

### Participants Indicated a Range of Barriers to Medicaid Medicaid barriers indicated by people with lived Medicaid experience (PLME), stakeholders, and overall, 2021



Source: WVCBP analysis

3 Rogombé, “Medicaid in the Mountain State,” (July 2021).

4 Kaiser Family Foundation, “Data Note: 5 Charts About Public Opinion on Medicaid,” (February 2020).

## Process Barriers to Medicaid

Both stakeholders and PLME indicated several process barriers to accessing Medicaid. Each of these process barriers could be addressed by implementing relatively simple administrative changes, which the final section of this brief will discuss. Key to understanding the process barriers identified is knowing the ways in which applicants can apply for Medicaid. In West Virginia, applications are accepted online via the WV PATH system, over the telephone with DHHR staff, via a paper application that is mailed in, and in-person at DHHR offices.

**Reaching DHHR by phone:** PLME consistently highlighted that they had difficulty reaching DHHR via phone. Nearly 50 percent of participants overall identified this as a challenge. Though most people apply for and renew Medicaid coverage via the online system or mail, calling the Department was the primary way they sought more information about eligibility, application, renewal, and details about coverage. Through several conversations, we learned that this problem emerged due to limited hours and long hold times. DHHR staff is only available by phone weekdays from 8:30am to 5:00pm, which can be incompatible with the availability of people trying to reach them. Furthermore, when people are able to call DHHR during business hours, they often encounter long wait times, some of which exceed 15 minutes, creating another barrier for PLME who are busy with work and family responsibilities during the day.

**Submitting paperwork:** Nearly a quarter of survey respondents and half of interviewees indicated that submitting application and renewal paperwork — such as identification and proof of income — created a significant barrier to accessing Medicaid. West Virginia’s online Medicaid portal where applicants apply for coverage, WV PATH, does not currently support uploading documents that verify income, household size, and other requested information. In practice, this means that after applying for benefits, applicants must wait for DHHR staff to process their application and contact them with a list of verifying documentation needed, and then either mail, fax, email or physically drop off any requested sensitive personal information at their local DHHR office. This results in an application process that is complex and lengthy for the consumer, requiring multiple steps and mediums in order to successfully gain health coverage. This needlessly complicated process makes West Virginia an outlier. In fact, it is one of just four states that utilizes a hybrid system wherein one cannot complete the entire application or renewal process online.<sup>5</sup>

**Additional challenges with online portal:** Beyond difficulty submitting paperwork, several survey participants also indicated that they or their patients had difficulty accessing or navigating WV PATH. While this barrier is often experienced in conjunction with trouble submitting paperwork, respondents indicated the problem in separate instances as well. Examples of challenges with the online portal include the website being down or having frequent error messages, cumbersome textboxes, and other features that make navigating WV PATH difficult. This is cause for concern, as the online system is the primary means of accessing Medicaid and other safety net programs in the state. This pattern requires additional conversations to better understand this observation.

## Socioeconomic Barriers to Medicaid

Socioeconomic barriers also impact access to and enrollment in Medicaid. While these barriers are important for policymakers to acknowledge and understand, the solutions to these obstacles will require a holistic approach involving multiple state agencies, advocacy groups, and other West Virginia entities beyond just DHHR.

**Limited broadband access:** One barrier that came up in nearly every provider interview and one-third of PLME surveys was a lack of reliable access to broadband or a device that connects to the internet. An estimated one-in-three West Virginians do not have access to broadband internet.<sup>6</sup> This phenomenon may partially explain the difficulty that several survey participants indicated in accessing the online system outlined in the previous section. This problem is a thematic one in the Mountain State and much of Appalachia. Lack of broadband or a device that connects to the internet inhibits peoples’ access to the online portal system, which serves as the primary means of applying for and renewing Medicaid enrollment. It can also make answering questions more difficult, pushing people to reach out to DHHR via phone or in the office, which, as aforementioned, can come with its own challenges.

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5 Kaiser Family Foundation, “Table 10: Medicaid Renewal Processes and Uses of Periodic Data Matches Between Renewals for Children, Pregnant Women, Parents, and Expansion Adults, January 2020,” (January 2020).

6 Randall, Stephanie, “Broadband Access is Essential Health Care,” (Charleston, WV: West Virginians for Affordable Health Care, September 2021).

Access to broadband is a complicated issue in West Virginia that varies significantly by region. Of the barriers discussed throughout this report, this was perhaps the most polarizing: while some people highlighted the need for a more robust online system, others noted that moving in this direction would not better their Medicaid experiences due to lack of broadband or a device that connects to the internet. This indicates the need for nuanced, multilateral policies that accommodate West Virginians with a range of experiences and needs.

**Unreliable transportation:** Lack of access to reliable transportation also impeded PLME access to Medicaid. Two-thirds of survey respondents and several interviewees highlighted that the distance to their local DHHR office was a barrier. The offices serve a critical role in the application and renewal processes as one of few options for submitting additional paperwork. In addition, they are a means by which a person can get answers to pertinent questions if they are unable or prefer not to call DHHR.

While DHHR alone cannot address issues as significant as broadband and transportation access, the Department can mitigate the impacts of these problems on Medicaid enrollees and applicants by addressing process barriers to Medicaid.

## Cultural Barriers to Medicaid

Cultural barriers may be the most difficult of the categories to address in the short-term. However, acknowledging them now can help address long-standing health inequities in the future.

**Negative attitudes toward Medicaid:** Participants indicated the existence of negative stereotypes and experiencing feelings such as shame and guilt in association with Medicaid and the safety net overall. Participants from both groups, including roughly 15 percent of PLME, indicated negative internal and communal attitudes that created a barrier to seeking Medicaid coverage. Several mentioned harmful stereotypes often associated with Medicaid recipients, such as poverty and low educational attainment. One parent indicated feeling guilty that they could not provide their family with private health insurance. Two stakeholders said they found these attitudes were even more prevalent among populations with substance use disorders and other mental health needs.

**Accustomed to hardship:** One interesting finding from this research was that the challenges associated with the Medicaid application, renewal, and enrollment processes outlined throughout this brief were simply seen as expected features of receiving public benefits for all PLME who participated in this project. Indeed, we found that many people did initially not consider these aspects of Medicaid as barriers at all, which made identifying the barriers that much more difficult in the early stages of the project. Once people were able to receive coverage, Medicaid played a critical role in their health. Across both groups, we identified feelings of Medicaid's necessity and recipients' satisfaction with the program overall. Reframing the scope of the project to include general and positive experiences, as well as better defining terms like "stigma" and "barriers" generated more robust and meaningful feedback from all participants, which was critical for our analysis and policy recommendations. But peoples' expectations of the process made uncovering barriers difficult, and we imagine that as we continue to better define terms, talk to impacted people, and deepen our relationships with them, we will uncover additional barriers.

## Recommendations

There are several opportunities available to mitigate the challenges highlighted in the previous section. Beyond streamlining and simplifying the enrollment and renewal processes in order to improve the Medicaid experience for consumers, these recommendations would also reduce the administrative workload for DHHR staff. This is particularly important as the COVID-19 public health emergency is expected to end in the coming months, increasing the administrative workload on the DHHR staff members that work on Medicaid by requiring full renewals of all Medicaid recipients. Together, these recommendations can improve the efficiency and responsiveness of the Medicaid program to the benefit of both consumers and staff.

**Maximizing *ex parte* renewals:** *Ex parte* renewals are those that utilize data that DHHR has access to — including existing income, payroll, unemployment, and other data — to confirm eligibility and automatically re-enroll qualified Medicaid enrollees without requiring any additional information from them, like completing renewal forms or submitting income verification documents. Because the *ex parte* process utilizes current income and household information from reputable sources, it is a reliable and accurate test of an individual's eligibility for Medicaid. Despite the significant amount of time and work utilizing *ex parte* renewals can save Medicaid staff and consumers, West Virginia has one of the lowest *ex parte* renewal rates in the country with less than 25 percent of renewals being processed this way.<sup>7</sup>

7 Wagner, Jennifer, "Streamlining Medicaid Renewals Through the *Ex Parte* Process," (Washington, DC: Center on Budget and Policy Priorities, March 2021).

West Virginia is lagging behind much of the rest of the country regarding this specific policy: currently, nearly half of states have *ex parte* renewal rates of 50 percent or higher.<sup>8</sup> West Virginia can increase its *ex parte* renewal rate simply by removing language from the application that requires applicants to actively opt into *ex parte* renewals. Such language is not required by the federal Centers for Medicare and Medicaid Services (CMS) and needlessly excludes recipients who are eligible for *ex parte* renewals. In fact, federal guidelines require *ex parte* renewals for all Medicaid recipients prior to sending out lengthy renewal forms. The West Virginia DHHR should begin *ex parte* renewals for all Medicaid recipients and stop excluding those who have not actively opted in or those who receive food assistance via the Supplemental Nutrition Assistance Program (SNAP). Doing so would align with CMS regulations and requirements and has been successful in increasing *ex parte* renewal rates in several other states, including in neighboring Ohio where the rate exceeds 75 percent.<sup>9</sup>

Increasing the number of *ex parte* renewals can streamline time-consuming processes and reduce the number of interactions PLME must have with DHHR once enrolled. As such, it can reduce the number of instances in which one may experience a barrier overall.

**Improvements to the online system:** Allowing online uploads of verification documents would greatly increase the efficacy of the online portal system and would ensure that West Virginians can complete their Medicaid applications all at once via a single platform. Every PLME who did not indicate experiencing broadband limitations signaled strong interest in better digital communications options, including the ability to upload documents to the website or an app. PLME also wanted to receive important communications via text message. Additional recommendations include simplifying language on the website and application materials, as well as shortening and streamlining questions on official documents and forms. Furthermore, offering on-site technical support can make the website more user-friendly. These contemporary tools can improve user experiences and create more efficient application and renewal processes.

**Utilizing telephonic signatures:** West Virginia is one of just nine states that does not allow Medicaid recipients to renew their enrollment over the phone utilizing a “telephonic signature.”<sup>10</sup> Having a multilateral response to West Virginians’ varied access to broadband is crucial to ensuring health equity. Allowing enrollees to finalize their renewal forms over the phone can help fill current gaps in the online system, particularly for PLME with limited broadband access, older recipients, and those receiving long-term care through Medicaid (whose application is not online at all). While West Virginia Medicaid enrollees may apply and report changes via telephone, they must receive, sign, and return updated forms via mail or in person to their local DHHR office. Employing telephonic signatures is another means of making the program more efficient, streamlining the process for both consumers and DHHR staff and ensuring that a renewal can be completed in a single setting. While allowing telephonic signatures would require DHHR offices to record and store a vocal signature, a majority of states have adopted this process without difficulty, and the increase in efficiency and time saved for DHHR staff would be well worth the investment.

While not exhaustive, the above process recommendations could make meaningful improvements to West Virginia’s Medicaid program, increasing health care accessibility for thousands in the Mountain State. Implementing these changes could mean the difference between a routine check-up and an expensive emergency room visit. But beyond these modifications to process, it is critical that lawmakers also address the socioeconomic and cultural barriers highlighted in this brief, as well as raise enough revenue to fully fund critical programs. Their contributions could help reduce stigma and challenge the status quo. Such action could help make significant improvements to Medicaid, public health outcomes, and quality of life in West Virginia.

*We would be remiss not to recognize our participants as the crux of this study. None of this work would be possible without them. Accordingly, we would like to express our deep gratitude to everyone who shared their time and insight with us — their contributions and expertise are meaningful and will make impacts across West Virginia. If you would like to share your Medicaid story, please contact Rhonda Rogombé at [rrogombe@wvpolicy.org](mailto:rrogombe@wvpolicy.org) or call or text (304) 873-6222.*

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8 Kaiser Family Foundation, “Table 10,” (January 2020).

9 Wagner, “Streamlining Medicaid Renewals Through the *Ex Parte* Process,” (March 2021).

10 Kaiser Family Foundation, “Table 10,” (January 2020).

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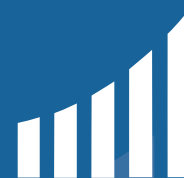
## About the Author

Rhonda Rogombé is the health and safety net policy analyst at the West Virginia Center on Budget and Policy. Rhonda holds a B.A. in economics and public policy and an M.A. in political science from Rutgers University-New Brunswick. Before joining the Center, Rhonda worked in non-profit and grassroots organizational settings within and outside of West Virginia, both of which inform her approach to research. Most recently, she co-founded the Black Business Boost and became a leader for the Climate Reality Project.

### West Virginia Center on Budget & Policy

8 Capitol Street, Fourth Floor  
Charleston, WV 25301  
Tel 304-720-8682 | Fax 304-720-9696

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