Medicaid and CHIP Coverage in an Era of Recession and Health Reform
Kaiser Family Foundation
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DIANE ROWLAND: I want to welcome you today to our next briefing on Medicaid and CHIP coverage we're looking at today and looking for tomorrow. For many of you, this may seem like a new endeavor but this is actually our 10th time to take an assessment of what the state levels for eligibility, for Medicaid and CHIP are and to look at how the enrollment procedures are structured at the state level and what that means for participation and availability of coverage especially for low-income children but also for their parents.

I'm Diane Rowland with the Kaiser Commission on Medicaid and the Uninsured and the Kaiser Family Foundation. We're pleased to welcome you this morning to our Barbara Jordan Conference Center for what I hope will be both an enlightening and entertaining discussion of some of the challenges and issues that the states are facing as they try and provide coverage for their lowest income residents.

We are going to be presenting the findings today from holding steady, looking ahead, annual findings of the 50-state survey of Medicaid and CHIP eligibility and enrollment. We

wanted to start with just a few charts to remind you of the issues that we are facing and why these coverage imperatives have become so important at the state level and are such a major feature of health care reform.

Clearly as we look ahead, we know that we are facing a growing uninsured population, which is the momentum for being able to try and provide better and broader coverage. One of the building blocks of that coverage will obviously be both the Medicaid and the CHIP programs but as this slide so graphically shows you, we've had an increase since 2004 of over seven million more Americans without health insurance coverage during the past several years.

What we see in that progress though is that the growing problem has been largely among the adult population. We have made some progress in some years of reducing the number of children without coverage and have held steady pretty much for coverage for children but in addition to that, we really need to think about what the challenges that the coverage that Medicaid and CHIP provide offer for coverage of the low-income population.

What we see here is that among the uninsured population, the most substantial share, 60-percent, are adults without dependent children. In most states, those individuals are ineligible for the Medicaid program because of the previous bar, until health reform for coverage of that population under Medicaid without a waiver.

Seventeen-percent of our uninsured are children, a target of trying to improve broader coverage right now as well as under health care reform. Another quarter are the parents of those children, adults with children under age 18.

As we look across the country, we know that if you are in one state and see one state Medicaid program, you have seen one state Medicaid or CHIP program and here we also see, you see very wide differences in the percent of the population without insurance coverage with large numbers of people without coverage throughout the south and much of the west and higher levels of coverage among the more previously industrialized northeast as well as some of the Midwest.

Clearly differences occur between rural and urban areas. It's really reflective of whether the economy provides

for a lot of agricultural base for a lot of small businesses but we see that the challenge different states will face will be very different in terms of getting their population covered but we especially are also going to see, as this report will reveal, that some of the differences in the current eligibility levels today for coverage for the lowest income population under Medicaid and under CHIP.

When we look at the challenges, we do see that among children, the Medicaid program and the CHIP program together provide coverage for over 60-percent of low-income children but parents and adults without children lag far behind since adults without children are only covered if they qualify either through a waiver or on the basis of disability. So these are some of the forces that we need to look at, some of the issues about how well this population is being served today and where some of the increases in eligibility will have to occur under health care reform.

I referenced, at the beginning, that this was our 10th year and I should really note that this has always, in our jargon, been called the Kaiser Report with Donna Cohen-Ross in

the days when she was at the Center for Budget and Policy Priorities. So this is the first year that we've shifted to have a new partner in Georgetown with us in Tricia Brooks and Martha Heberlein and Jocelyn Guyer.

I'm pleased that they picked up the responsibilities here for continuing this important survey that we do in collaboration with our partners. I'd also like to recognize and thank Samantha Artiga and Jessica Stephens of the Kaiser staff who have helped to put this together and without whom we would never have gotten all those tables out so that you can now look at every state by state issue, which will be also featured on our state facts website.

So without further ado, I'm going to start our discussion by asking both Tricia Brooks of the Center for Children and Families at Georgetown and Samantha Artiga, Principal Policy Analyst with our Kaiser Commission on Medicaid and the Uninsured to present some of the findings to you.

Then we're going to turn to three very notable individuals to provide some perspectives, Cindy Mann known to all of us as the deputy administrator and director of the

Center for Medicaid, CHIP, and Survey and Certification at the Centers for Medicare and Medicaid Services; Joan Henneberry, the Executive Director of the Colorado Department of Healthcare Policy and Financing, and Mary Watchel, the Director of Health Policy for Voices for Ohio's Children to just provide some perspectives on the findings that we'll present today.

Full bios as well as all of the graphics being used in the PowerPoint presentations are in your packet. So without further ado, let me turn it over to Tricia to start off our findings. Thank you.

TRICIA BROOKS: Thanks Diane. I want to start with saying that at the Georgetown Center for Children and Families, we were delighted to be asked to be involved in this work. As a former CHIP director, I really know what an invaluable resource this report has been to state officials, to policy makers, to all of us policy wonks in the room and advocates alike. So it is truly our delight to be part of the partnership.

Diane recognized the members of the project team but I want to say that I can't imagine working with a better team,

one that's more committed to getting it right and when you look at the nitty gritty details in this report, there's a lot to try to get right.

So thanks to Samantha and Jessica and Martha and Jocelyn for all their great work on not only the report but the surveys and the collection and crunching of the data behind that.

Ditto, Diane's comments of recognizing Donna and her colleagues at the Center for building a strong foundation and last but not least, we would be remiss if we did not express our deep appreciation to the state officials who shared their time and their knowledge, who gave us the foundation for this report. Truly without their participation and probably more their patience, this project would not be possible.

So very quickly about the survey, as Diane mentioned, it's the 10th in the series. It's based on extensive telephone interviews with state officials. It covers eligibility rules, enrollment, and renewal procedures, and cost sharing practices in both Medicaid and CHIP as they relate to children, pregnant women, and parents.

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This year, we included more questions about coverage for adults without dependent children. We probed a bit more into systems and technology. This survey provides a snapshot of policies in place as of January 1, 2011. It also highlights the changes made during 2010.

Let's start by looking at the key factors that impacted state policy over the past year. In 2010, the economic downturn continued and families across America continued to face economic uncertainty due to persistently high levels of unemployment. The corresponding loss of access to employer-sponsored insurance created an increased need for public coverage. This put added pressure on state budgets that were already stressed by the bad economy and decreased state revenues.

However, the increased federal support for Medicaid through the Recovery Act bolstered the ability of states to meet this increased need for healthcare. This extra financial help was accompanied by a maintenance of effort provision that states hold steady in their Medicaid eligibility levels as well as their enrollment and renewal procedures.

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2010 also saw the enactment of the Affordable Care Act, which among many other important provisions, establishes a new eligibility floor for Medicaid at 133-percent of poverty for all Americans in 2014. Not only does this end the historic exclusion of childless, non-disabled adults in Medicaid but the ACA gives states the flexibility to expand Medicaid early.

The ACA also extended the important maintenance of effort protections to children covered in CHIP. Lastly the options provided through reauthorization of the Children's Health Insurance Program, or CHIPRA, also helped shape state activity in 2010 as it had in 2009.

As a result of this policy and fiscal environment, Medicaid and CHIP were strikingly stable in 2010 with all but two states maintaining coverage for children and adults. States provided much needed coverage and peace of mind to families while they looked for jobs and struggled to pay the bills.

Without Medicaid and CHIP, the uninsured rate, which reached a record 50 million, most certainly would have been higher. Some states actually went beyond maintaining coverage

to make targeted expansions and program improvements. As we've seen in past surveys, most of these changes, which affect eligibility and efforts to achieve administrative efficiencies by removing red tape were focused on children.

One notable trend continues. Access to coverage for parents does not come close to matching that of their children. Coverage for non-disabled adults lags even further behind. States are progressing in their use of technology to reduce paperwork and streamlining procedures but most states have a substantial amount of work to bring their systems' capability in line with consumer-friendly, paperless systems that are envisioned by the Affordable Care Act.

So let's take a closer look at the top line survey findings. A total of 13 states expanded eligibility by either raising income limits, by using CHIPRA to cover lawfully residing immigrant children and pregnant women or by taking up the ACA option to expand adult coverage through Medicaid early. Fourteen states also made improvements to their enrollment and renewal procedures. These actions were varied and ranged from dropping the asset test or face-to-face interview requirement

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to adopting presumptive eligibility, 12 months' continuous coverage, or express lane eligibility.

I'll cover some of these data as they relate to children and then turn it over to Samantha to talk about adult coverage and wrap up with a look ahead. In 2010, three states, Kansas, Colorado, and Oregon, raised income eligibility in their CHIP programs.

Oklahoma also expanded coverage to some children through its premium assistance program. As a result of these expansions, half of the states including D.C. now cover children at 250-percent of poverty or higher. Only four states have income limits below 200-percent of poverty. Arizona was the sole state moving backward for children by putting a freeze on enrollment in its CHIP program before the CHIP Maintenance of Effort Provision went into effect.

As a result of the continued improvements in enrollment and renewal procedures, nearly all states have now eliminated face-to-face interview requirements for children at both application and renewal and no longer look at assets when determining eligibility for these programs.

Almost all states allow the maximum 12 months before a child's eligibility must be renewed but less than half of the states assure a full 12 months of continuous coverage. While we've seen progress in the use of technology to verify income through other data sources such as wage databases or tax agencies, only 12 states use this capability to eliminate paperwork for new applicants and 18 for those who are renewing coverage.

Thirteen states now use presumptive eligibility in both programs to allow qualified entities such as hospitals or community health centers to screen eligibility and temporarily enroll children so they can get needed services while their parents complete the regular application process.

Since its enactment in February of 2009, we're getting really close to celebrating the second anniversary of CHIPRA. CHIPRA has helped shape state activity. Now without a question, the most prevalent improvement made in 2010 was adoption of what has proven to be a highly efficient and accurate way to verify citizenship through an electronic data match with the Social Security Administration. This option

proves so popular that we felt it overshadowed the other activity in states and we chose not to include it in the count of states that made overall improvements.

Twenty-nine states have successfully implemented the SSA match after it went live on January 1st of 2010. They have reported significant gains in administrative efficiency not to mention reduced paperwork burden on families. Fifteen more states indicate they plan to adopt this option in 2011. Another popular CHIP provision removed the five-year waiting period before states could secure federal match to cover lawfully residing immigrant children and pregnant women. A total of 21 states have lifted the five-year bar for children and 17 for pregnant women.

Six states are early adopters of the new express lane eligibility option, which allows states to use the findings of other programs such as SNAP or food stamps to enroll children in Medicaid and CHIP. Overall these continuing gains, even in the face of tough economic times, illustrate our country's, the President's, and governors' commitment to children's coverage,

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a commitment that has resulted in a record 90-percent coverage for children.

That's pretty phenomenal in the best of times not to mention in these tough economic times. Now unfortunately the picture isn't quite so rosy for adults but there are some positive exceptions and I'll let Samantha share those with you.

SAMANTHA ARTIGA: Thanks so much Tricia. As I think the information Tricia presented made very clear states really have achieved some significant progress in covering low-income children and that's really evident in this figure here.

You see the median eligibility threshold in Medicaid and CHIP for children now reaches above 240-percent of the federal poverty level yet it's also really clear how far behind coverage lags for their parents and for other non-disabled, low-income adults. You'll see that for parents the median eligibility level remains well below the federal poverty level.

As was mentioned earlier, other low-income, non-disabled adults generally remain ineligible for Medicaid reflecting the fact that prior to the passage of health reform,

states could not cover these adults through Medicaid unless they obtained a waiver to provide that coverage.

So looking nationwide with the addition of an expansion in eligibility for parents in Colorado during 2010, you'll see that 18 states including the District of Columbia now provide coverage, Medicaid coverage, to parents up to at least the federal poverty level.

However, in 33 states, parent eligibility is still restricted to below the poverty level with 16 states limiting eligibility to below half of poverty, which equates to about $9,000 per year for a family of three.

Turning to look at coverage for other non-disabled, low-income adults, during 2010, the District of Columbia and Connecticut moved to take up the new option provided in health reform to move early to cover these adults and moved some adults they had previously been covering with fully state or local funds to Medicaid. Minnesota has also since moved to take up that option but that movement took place after our survey period and therefore that change is not reflected in our survey findings.

Also in 2010, California obtained a waiver to continue and expand some existing county coverage initiatives serving low-income adults. However, even with these advancements in 2010, what you see here is that currently only seven states including D.C. provide Medicaid or Medicaid-equivalent benefits to low-income adults without dependent children.

Additional states do provide more limited coverage or premium assistance to some of these adults but generally, these adults remain ineligible for assistance in most cases regardless of how low their income is.

Beyond coverage, what this figure shows you is that simplifications in enrollment procedures also lag behind for parents relative to their children. Certainly a number of gains have been made in recent years but as you see here, while all states have eliminated the asset test for children, nearly half still require that for parents and more states continue to require face-to-face interview requirements for parents as well.

Overall, what the data show is that although progress has been made that there's certainly still room for improvement

in simplifying procedures for parents and certainly room to better align the policies between children and parents, which will become even more important under health reform.

Then turning a bit to look at states' use of technology, which Tricia commented on a bit in her remarks, as states have been moving forward with simplifications in their procedures, they increasingly are turning to technology both to reduce burdens on families as well as to achieve program efficiencies.

As she noted for example, more than half the states took up the new option to use an electronic data match to verify citizenship with the Social Security Administration and a small but increasing number of states are also turning to use electronic data match to verify other aspects of eligibility.

However, states still have a really long road ahead to develop the integrated web-based technology-driven enrollment systems that are envisioned and required under reform. As you see here, while 29 states offer an application that can be submitted electronically with an electronic signature, in most

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cases, families still are required to submit paper documentation either through mail or fax.

There are some states that still are relying on almost entirely paper-based systems. So given that a number of states are going to need to make large-scale improvements in their systems to create what is envisioned under reform, it's really important for them to begin taking action now to be prepared by 2014.

There's been some recent federal activity along this front to help support state efforts including a proposed rule to provide a 90-percent federal match rate for systems development, some new grant funding opportunities as well as new guidance released related to IT systems.

Then finally to wrap up with just some key thoughts to think about moving forward, I think in the immediate term, it's clear that states are facing a really difficult budget situation. State revenues remain depressed. The enhanced federal matching funds provided through ARA will expire in June.

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States are continuing to experience enrollment pressures due to continued increased need for coverage, which will continue until the economy more fully recovers. Keeping Medicaid and CHIP coverage stable is going to be very important for continuing to fulfill families' need for coverage and preventing increased growth in the uninsured looking forward and also for providing a base for successful implementation of health reform in the coming years.

As states look to implement health reform, they face both challenges and opportunities. They face the challenge of preparing to implement the expansion and upgrading their eligibility and enrollment system amidst budget pressures, which obviously limit their resources and administrative capacity.

However, at the same time, health reform also provides states new opportunities and new options to really vastly streamline their eligibility in enrollment procedures, creating new efficiencies in the program, and to really transform their programs through the use of technology in greater ways.

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Health reform clearly also provides a really significant potential opportunity for states to reduce the uninsured rate through the expansion in Medicaid coverage, which will eliminate that longstanding gap in coverage for low-income childless adults and provide millions of these currently uninsured adults a new coverage option. So we will plan in the next year to continue to track state efforts on these fronts and anticipate that we'll continue to see action along these fronts in 2011. With that, I'll close and turn it back over to Diane.

DIANE ROWLAND: Thank you Tricia and Samantha and now we'll turn to Cindy to kick off our discussion.

CINDY MANN: Thank you Diane. Thank you Tricia and Samantha. These are enormously helpful findings for us in terms of understanding where we are now on the road ahead and I think as both Tricia and Samantha have said, they're really heartening findings given the very difficult fiscal times that we find ourselves in. Overall, coverage has been maintained and even strengthened thanks to the support of successive pieces of federal legislation, CHIPRA, the Recovery Act, the

Affordable Care Act, and of course the very strong and concerted efforts on the part of states.

So as a result in these difficult times, Medicaid has lived up to really one of its most fundamental features, which is that it is a countercyclical insurer unlike other types of insurance. Medicaid is designed and intended to expand its reach in difficult times when there are more people who qualify for its coverage and need coverage through Medicaid because of either loss of income or loss of employer-based coverage or both.

So we're very heartened by the actions taken by states to move forward and we think that many of the options provided in CHIPRA and in the Recovery Act and the Affordable Act have really provided some useful tools.

So the new options, just to review some of where we've seen the federal legislation actually translate into real improvements for people, as noted Connecticut and the District of Columbia have taken advantage of the new early option to cover childless adults that were created in the Affordable Care Act and we have actually now since the study was released, a

second waiver, Samantha mentioned that California has a waiver to expand coverage for childless adults through its county-based initiative.

Washington State has been granted a waiver after the date of the survey to help keep its Basic Health program going forward, which covers childless adults and other parents.

Twenty-seven states have picked up the Social Security Administration option. Six states have express lane, also both of these are CHIPRA options. Twenty-seven states have dropped the five-year ban for children. Seven states have done so for pregnant women in terms of coverage of lawfully present children and immigrants.

We note also that not only do these provisions either stabilize coverage or advance coverage but they have also served the purpose of helping states fiscally. In some states, the new coverage option has helped states bring federal dollars to state-funded programs where states have been struggling to provide their own dollars, obviously an increasingly difficult thing to do in these fiscal times.

In some states, the new options like the social security match and the express lane eligibility can reduce administrative burdens for states making it easier for states to process applications and renewals and to recognizing there's a great deal of cutbacks in terms of state resources on the administration side. So I wanted to just note a few other initiatives that we've been working on to help coverage move forward.

Last week, we were very excited to announce 15 states had qualified for what's called performance bonuses. Those are bonuses provided in the CHIPRA legislation that recognize when states are particularly successful in enrolling the lowest-income kids, kids eligible for Medicaid.

Those 15 states deserved their bonuses and put out their own state dollars to cover those children and the bonuses are there to help them shoulder some of those costs. There's over $200 million in bonuses that we provided to states through this initiative, a great deal more than what was available to states in 2009.

Over the last year, we've also provided outreach grants to 68 grantees in 42 states and 41 tribal organizations in 19 states. These are again CHIPRA grants to provide outreach and enrollment assistance in the communities. Sometimes these are state grantees, often they are community-based organizations and most often, they are groups and states working together in coalition to really move coverage forward. Also as noted, the activity around all of this simplification and improving coverage as we move forward really helps us lay the groundwork for implementation to 2014.

The performance bonus grants, for example, not only are awarded to states because they've been successful in enrolling more children but also because they have adopted certain program features in their Medicaid and CHIP programs, which simplify the enrollment and the renewal process that in turn produces greater enrollment but also produces the kind of system that we have all come to realize is what people expect, people want, and people need if they're really going to be able to access the coverage that they need and that they're eligible for.

We believe strongly in this Administration about the importance of each state having a simple, data-driven, consumer-friendly enrollment experiences and we're putting our energy, our policy, and some of our money towards that goal.

As was mentioned, we issued a notice of public rulemaking in November that we're proposing to raise the federal match rate to 90-percent for states' improvements in their eligibility systems as they're all needing to do as we move to 2014. It is not business as usual. We are collaborating with states to make those systems very consumer-friendly, very data-driven, very nimble, and able to serve the needs of the population as well as states.

We think these are the kinds of attributes, better financial support, better technology, more nimble and more effective systems that really what the public wants and ought to have and that states are really very eager to provide as we move towards 2014.

The rule isn't yet final but we hope that the final rule, whatever it says, and the related support that we're able to give along with our colleagues at the Office of Consumer Information and

Insurance Oversight, OCIIO as it's fondly known, will really provide for a very positive, accurate, and timely enrollment experience for everybody. We will no longer even have the phenomenon of people being eligible for public coverage but yet not enrolled.

So I just want to acknowledge the great benefit that this survey has provided over the years and continues to provide. It really offers all of us, including those of us in the Administration, a benchmark and a roadmap for thinking about the tasks ahead. So thank you.

DIANE ROWLAND: Thank you Cindy. Joan will now provide a little state perspective.

JOAN HENNEBERRY: Thank you very much and thanks for having me here. We started our health policy and health insurance reforms in Colorado in 2007 and that was, of course, when the economy was better and Colorado's economy is still much better than many of our colleagues in other states but we had very aggressive and pretty well financed outreach efforts. We launched an initiative to enroll all of our children in medical homes.

We were rebuilding our medical management, care management programs, increased reimbursement for providers but by the middle of 2008, all of that was turning around and we knew that the only way we were going to be able to expand eligibility in our public programs, and at that time we were at federally mandated levels in Medicaid, a little bit higher on the income scale for CHIP kids, up to 205-percent of poverty but we knew that there was no way we would be able to go any further without an entirely new revenue source other than state general fund revenues.

So we worked for a year with the hospitals and the hospital association to develop a bill that would allow us to assess a provider fee on hospital beds and use that fee to draw down that federal match and then what's a little bit different with our hospital provider fee than what most states have done in the past with, I believe the exception of maybe Wisconsin, the hospitals agreed that the revenue from those fees and the federal match could also be used to expand eligibility in our public program.

So yes we do use that money to pay the hospitals closer to what it actually costs them to serve a Medicaid client but the second priority for those dollars was to use that money to expand eligibility in our public programs, which we had done, we have done now.

It took us an entire year to work the legislation. Then it took a second year to do all of the planning and systems work and benefit design and working with CMS but we did get our plan approved and began enrolling people in May of 2010.

So we expanded eligibility as you saw in the chart, from 60-percent of poverty for parents to 100-percent and for children and pregnant women from 205 to 250. Since May, we've enrolled now about 30,000 individuals into Medicaid and CHIP and those are mostly the parents, a fairly small number of kids actually because we'd enrolled so many kids already but it was very clear that there was huge pent-up demand and unmet need among the parents of our low-income children.

Then the next two phases of the use of those dollars this year, in 2011, we will roll out the third phase, which is

expanding eligibility for a disabled buy-in program up to 450-percent of poverty and then in 2012, we will create a new program and offer Medicaid to adults without dependent children up to 100-percent of poverty.

So we expect to be on track for that. The main thing that would hold us back would be systems problems or political wind shifts, which I'll talk about in a second but we expect to go forward with that, which will give us a very solid base on which to build toward 2014 if we can get all of our populations and good enrollment up to 100-percent of poverty by the end of 2012, mid-2013, we feel we're very well prepared for 2014.

We had no idea, at the time when we began this planning of course and we had a start date of May 2010 in mind from the beginning of when this bill was developed and the bill was passed, we had no idea that literally our go-live date was going to be within 72 hours of when we thought the President was going to sign the health reform bill.

That was very, very important. If you know anything about the maintenance of effort issues and the start-up date issues and what happens to you in 2014 if you started before or

after the signature, we really were in the Governor's office on a Monday morning deciding whether we go or no-go based on whether the President was going to sign the bill. It turned out well for us and it will certainly work to Colorado's advantage in the long run.

So let me just, they invite state people to sometimes sound a little negative or I would like to say bring some reality to the discussion. Many of you in this room know me and know that I lived and worked in this city for years and it was a great experience but sometimes you do need to get outside and get a little dose of reality.

So the political winds right now are very, very difficult even for a state like Colorado that we're touted as being what I call the next generation states. We're not the pioneer states, one of the pioneer states that worked on health reform. We did all of this work with great support from our Governor. We couldn't have done it.

We could not have done what we did without the Governor and with almost bipartisan support in the legislature and lots of support from the health care community, fabulous, fabulous

support from the hospitals, from the medical society advocacy groups, you name it.

The fact is the budget is still pretty rotten. Again we're not nearly as bad off as many states. We're facing, we think we've done all the cuts we have to make. We've already done three rounds of cuts in the '10-'11 budget, the current fiscal year we're in.

We think we're done but there's at least one more round of revenue forecasting that will happen. We've submitted a budget for the 11-12 year that starts July 1 and we know that is probably $1 billion short for the entire state. Our state general fund, I think, is, I don't know $15 billion maybe.

So the budget cuts aren't finished. We know 11-12 is still going to be a bad year. We hope 12-13 will stabilize a little bit more and we're seeing a little bit of a slow in the growth of enrollment in our public programs but there's still thousands of people enrolling every single month, thousands every month.

We're working hard to make that happen. I mean we very much believe that if the policy allows for people to receive a

benefit, we want them in the door. That's the whole point. If we're not going to work really hard to get people the benefits that the policy makers have said they should have then there's no point in doing that but we are worried about that quite a bit.

Like every state, we have a whole slew of new elected legislators who start their day tomorrow, start their session and someone has already dropped a bill to repeal our hospital provider fee.

Now it's not going to pass. It may get out of committee but there's still enough people who support it and there's still enough political wrangling that it won't pass but it's just an indication of not just the lack of support for the things that we all believe in, but a lack of knowledge with all of the new players both on the executive side and on the legislative side, people who just genuinely do not understand that by having a hospital provider fee and expanding coverage to 100,000 more people in Colorado without the use of general fund, what a gift that is to be able to do that.

To repeal it really does nothing to save general fund money. It just sends a political message about whether you believe in public insurance or not. We're experiencing a lot of what I call federal fallout in Colorado and I think many states are. The rhetoric that goes on in this town sort of trickles down and gets out to states and you hear the same sort of thing.

A number of key legislators in our state who oppose what we're doing not because they don't think we should be helping low-income families, they don't believe we should be doing anything to contribute to the federal deficit.

So even when I say things like well we're expanding coverage without general fund, they say well I don't care because you're still drawing down federal match and that's contributing to the federal deficit.

So you're getting those kinds of arguments and at the same time, we have somebody who's dropped a bill who wants us to do a single payer plan and get a mega-waiver from the federal government and just take all of your money and do whatever we're going to do with it. So it's just a very

interesting environment out there in the states. I don't think we're unique in that sense.

The last thing I'll say more germane to this conversation that we are one of the states that has county-based eligibility and enrollment. So we only have five-and-a-a-half million people and we have 64 counties.

So 64 administrative structures, 64 counties with hundreds of workers shuffling paper and frankly the counties are very resistant to some of the changes that we have been trying to make and that are reflected in this report, electronic exchange of data, eliminating all the paper online, self-service kinds of things.

Those are jobs. Those are jobs to counties and no matter what we say about how important it is to families and making life easier for the families, county commissioners cannot afford to be running for re-election when they've laid off county workers because we're doing a better job.

So that's just a political and the reality of some of the dynamics and the tensions that can occur and you can get beyond those. You have to build lots of support and coalitions

and get enough people on your side to move forward with those things but it's not always as easy as one would like.

DIANE ROWLAND: Thank you Joan and we don't just have you come with negative views. We have you come for a dose of where the rubber meets the road. Thanks.

MARY WATCHEL: I'm also glad to be here. It's fun to be with friends and a lot of folks in the audience including on the panel, Cindy and Tricia who have worked very closely with Ohio over the last several years and helped to get us to where we are. I'm one of those persons who looks forward to this report every year, pours over its findings and we use it nonstop to inform our work and our strategy and educate the work in Ohio. So thank you for once again a great report and giving me the opportunity to be here.

My organization, Voices for Ohio's Children, works to improve public policy for the lives of Ohio's children and families. We're part of Voices for America's Children, the national network of child advocacy organizations. So I'm coming from the perspective of that intersection of where public policy decisions impact lives and kind of a foot in both

worlds. So I thought what I would do with my time today is to tell you a little bit about what's happened in Ohio in the last year as a way to illustrate some of the policies and the terms you've seen in this report and to maybe bring it down to one more level.

Just very briefly, we're a large state, as folks know. We very much mirror the themes that are found in the report so I won't go into detail on that but the big story and I think why I'm here is that in 2010, Ohio had a fast track on implementing some simplification measures. I wanted to give you a little more background on how that came to be because I think it's very helpful to illustrate this.

As the report states, our now former Governor Strickland was the first Governor to accept Secretary Sebelius' challenge of connecting kids to coverage and he did this back in March, on March 10th as part of our covering kids and families conference and he committed at that time to making sure that all of Ohio's uninsured eligible kids would get enrolled within the next five years. We think we don't have to wait that long.

As a way of doing that, he also committed to some simplification policies including presumptive eligibility for children and pregnant women, 12-month continuous coverage for children and express lane eligibility. Exactly three weeks later on April 1st, Ohio had implemented presumptive eligibility for children and also 12-month continuous eligibility. That's a big deal.

I really have to give credit to our technical assistance team of Tricia Brooks and Donna Cohen-Ross who looked our state officials in the eyes and frankly the advocates and said you can do this. Indeed that was true. CMS was a great partner in helping us navigate that but the big lesson, obviously the 30,000-foot lesson is government can work fast and efficiently when it has to and when it chooses to.

Beyond that, there are a couple of lessons I wanted to share. Leadership counts. I mean we have been making steady progress on various simplification bits and pieces over the last few years in our state offering telephone renewals, doing 12-month renewal for parents, things like that.

There was a lot of interest and support among administration and legislative officials to keep going farther but it wasn't until the Governor said we will do this that we were actually able to take those steps.

Backing up, laying the groundwork makes such a difference. Joan kind of alluded to some issues. We are also a county-based eligibility system with 88 counties in Ohio and almost 12 million people. So these changes are much more than policy and operational changes. They're at their core cultural changes in the way that we approach public programs. So that's a piece of work.

On the other hand, we have through the advocacy community, worked very hard over the past several years to lay the groundwork for these reforms. I can literally say that everyone from Governor Strickland himself to cabinet directors to legislative leaders to our partners in the county eligibility agencies know what churning is.

They know that two-thirds of Ohio's uninsured kids could right now be covered on Medicaid. So we have to focus on making our current program stronger. They know what are some

policy options and tools that are available to help us address this problem.

So the Governor's public announcement and commitment didn't come out of the blue. It was part of a narrative that had been constructed over the years and developed and supported by data and what other states are doing. I think that was evident by the bipartisan support that it enjoyed.

These were administrative decisions. The Governor did not need the legislature to approve this but by April, we also all knew that our state was facing a pretty stiff budget deficit and on the one hand, when you look at these policies, cost more money, get more kids into Medicaid, keep them covered longer. Why are you growing a budget in a deficit period?

On the other hand, it brings efficiencies to the program. It does what we said we're going to do. What we committed to doing is to covering uninsured kids especially the poorer kids first. So when the little administrative part that needed to happen of going to the controlling board to approve these policies, we had no problem. The issue of cost was not

raised. I think that was pretty remarkable too at that point in time.

Then the third lesson, Cindy, incentives work. Our aggressive timeline was driven very much by, solely, by the possibility of securing the CHIPRA performance bonus dollars. We had to hit an April 1st deadline in order to qualify and then that's exactly what happened.

Ohio was one of the 15 states who was recently awarded the performance bonus at the end of December. So we're very proud of that. We're working very hard to make sure at least some of those dollars are reinvested back into further simplification as well.

I think the fact that those bonus dollars are available for the next several fiscal years, hopefully, will help us hold on to those measures, we are not protected by the MOE because we had an April 1st implementation but we feel good that there's an argument to be made for continuing regardless.

So I just wanted to spend a couple of my last minutes talking more broadly about why these policies matter. I think that clearly the simplest message is that Medicaid and CHIP

work. We mirror the country in terms of we've been able to hold steady and see improvement in our child uninsured rate only because we have an effective Medicaid and CHIP program.

Coverage alone isn't the picture. We know that but coverage also matters. Children who are enrolled in Medicaid and CHIP are more likely to have well-child visits, to have their vaccinations, more consistent medical treatment. They also have fewer hospitalizations and emergency room visits than uninsured children. So the data's very clear on that.

I think an evolving understanding is how stability of coverage also matters. So we've been able to really build some nice partnerships with the provider community who very much see what we have at stake is real different to try to provide consistent care to a child who's tenure on Medicaid might be seven months compared to a child who can maintain that coverage for several years.

So that's why a policy like 12-month continuous eligibility matters. It also means from a family perspective a working mom who is in line for a modest raise or maybe picking

up more hours at her job may have to make a decision whether or not that would put her child's coverage in jeopardy.

With 12-month continuous, at least for that year, that's not a question. In Ohio, most of our kids on Medicaid are now clustering at the lower income eligibility level but I have talked to moms who are near that cusp of 200-percent and are faced with that decision. At least now they can have some peace of mind that that won't happen during that year.

Also the cutting red tape helps our eligibility agencies, our county agencies that managed growing caseloads. Our county GFS agencies are very frankly overwhelmed. Over the last four years, they've had a 40-percent cut in their funding. At the same time, many of the programs that they administer have seen a demand of larger than 50-percent. Statewide, our 88 counties have 3,250 fewer staff than just three years ago. So clearly streamlining and modernization are absolutely vital for our eligibility system.

When counties could start offering telephone renewal, they report less crowded waiting rooms, less amount of time it takes a caseworker to process a case. I think looking forward

of great interest for both the agencies and advocates is exactly what Tricia and Samantha were talking about, a better use of data matching to verify information upfront rather than asking families to produce paper. We're one of those antiquated, outdated eligibility systems. It will be a stretch but I think there's absolutely a sense that that is the next step we have to take.

So in closing, I guess the last thing I would say is at the end of the day, the very simple truth is it is about kids. Over and over, the public has demonstrated strong support for kids' health and behind the statistics are real people. I just wanted to share three vignettes. A colleague recently talked to a dad in Cincinnati who has three kids.

He's currently unemployed. He gets $1,290 per month on unemployment compensation and he's been paying $960 per month for COBRA coverage. He had no idea that he and his kids qualified for Medicaid but thanks to a local outreach program, he now knows and he's getting help to apply.

I talked to a couple last year who are longtime small business owners but their revenues had gone down and they could

no longer afford to pay for health coverage out-of-pocket but they still had a son in junior high school who likes to play sports. So the mom found us online, picked up the phone and literally said I never thought I'd ask this but how do I get my son on Medicaid?

Then finally, our friend Emily who some folks here have met, she's a six-year-old girl with Down's syndrome. She was uninsured for almost two years because her self-employed father made too much for Medicaid and she couldn't get affordable health insurance because of her pre-existing condition.

Her family situation changed and she now is on Medicaid and she's getting the services she needs. Her parents have peace of mind at least if not for themselves, at least for their daughter. So all of these efforts that we do to make this program accessible, to make it effective really, really matters.

DIANE ROWLAND: Thank you. Now we'll turn to some questions from the audience. If you would please raise your hand so a mic can find you and then identify yourself before you pose your question. Thank you.

CATHERINE FINLAY: Hi, my name's Catherine Finlay. I work with some Medicaid providers and Cindy, this is for you. I don't know how much you can say but I'm just curious. We've heard a lot about the Colorado hospital provider tax and as you know, there's an important provider tax that's kind of floating around CMS and OMB in relation to MCO provider tax.

I'm just curious if I saw in the HHS' blueprint for the 2011 regs that there's a placeholder for the provider tax on MCOs. I'm curious when that might come out, if there's anything you can share with us about that? Clearly given the economic situation, there's a lot of states that are concerned about it.

JOAN HENNEBERRY: It's a fee not a tax [laughter], very important distinction. I learned a lot being in Washington.

CINDY MANN: I think you're referring to, there's a regulation that we had been planning or that we are planning or working on that relates to the changes that were established in 2007 really around states' ability to only tax Medicaid MCOs, managed care organizations.

The idea of a provider tax is that they are fine and many states, as Colorado's story illustrates, are using them as a way to finance the nonfederal share. What they can't do is just be a way to recycle dollars from the federal government without any real state contribution even if it's not general fund contribution but real dollars there.

So we were looking at some provisions related to the implementation of the 2007 law. So I can't tell you exactly when that might come out. It's still under consideration.

I just would add that many states though are, Colorado, California, many states are moving forward with provider taxes and we're working closely with states to design them in ways that work under the federal law.

DIANE ROWLAND: Okay next question.

JENNIFER LUBELL: Hi, Jennifer Lubell, *Health Reform Week.* Does Kaiser have any updated figures on how many uninsured, low-income adults under the health reform law are going to be covered in 2014 versus how many are being covered now?

DIANE ROWLAND: That would be you Samantha.

SAMANTHA ARTIGA: We don't have any breakouts that specifically look at the adults without dependent children in terms of actual numbers either, projected under health reform or work currently that break them out as a separate group. I think we do have some estimates that look at adults overall but I don't think it breaks it down to that specific level of adults without dependent children.

JOAN HENNEBERRY: This might be something we should talk with you guys about because states, in their exchange planning grants, are doing a lot of modeling to look at that population because many of us have done household surveys and other kinds of surveys where we have some pretty decent numbers about which program people are going to go into whether it'll be a Medicaid-eligible person or somebody in the exchange but we're kind of digging deeper into those data.

It may be something we could work with you all about to collect it at least from the states that have already started doing their modeling.

DIANE ROWLAND: But we do know that the bulk of the adults under 133-percent of poverty who are uninsured are

adults without dependent children and that they will be one of the major groups being brought in. There'll be a challenge, obviously, for some of these enrollment procedures that we talked about today that are used to picking up the parents of children and/or the children and this is the group that has been outside the Medicaid system so may require some very different enrollment and outreach efforts than the ones we're talking about today for the populations already covered.

JOAN HENNEBERRY: Can I second that because in our modeling, this is a very diverse population in a state like Colorado. I mean you have everything from fairly healthy people who live in ski towns and don't make very much money and live somewhat poorly by my standards because they choose to live in a ski town and spend their discretionary income on ski passes and Starbucks [laughter] versus adults without dependent children with severe mental illness who are homeless and waiting for their disability designation.

So this is a very large, diverse population and we don't pretend for a minute to know exactly all of the different techniques and approaches we're going to have to take to ensure

that we find the people that we convince them that it's okay to enroll in a government program.

I mean this is something we think about a lot. I think states are very cognizant of the upcoming challenges that we will all have to make sure that that population gets their health care benefits.

CINDY MANN: The one thing I would just add on thinking about the enrollment, there's about 16 million people at least that the Congressional Budget Office projects will be gaining coverage in Medicaid and CHIP as a result of the Affordable Care Act. Most of those people will gain coverage through Medicaid.

Most of those people, as Diane suggests, will be the adults and adults without children simply because as the data show, there's very little coverage currently available to those individuals. So they make up a large segment of the uninsured population. We are, as you look at the kind of guidance that we've been putting out over the last couple of months, we together with OCIIO, very much think of the enrollment and the enrollment process as being on a continuum.

So it's Medicaid, it's CHIP, it's the exchange, so it's not going to be siloed. So we need to do some very targeted outreach, as Joan indicates, because different people are in different circumstances but on the other hand, there's going to be very broad outreach generally to people who are uninsured saying now there's coverage for you.

I think that will really change the way in which we have opportunities to bring people into the system and then the system itself being anticipated to be seamless and not siloed will then contribute to the ability of people to get enrolled in the appropriate program at the appropriate time.

DIANE ROWLAND: Okay, next question?

LUCY WILSON-KIER: I just want to take this time to say thank you. My name is Lucy Wilson-Kier from the Department of Health Care Finance in the District. My question goes to Joan. I want to say thank you for your presentation, your briefing but I just want to know that what approach or strategy did you use in getting the beneficiaries involved in the system?

JOAN HENNEBERRY: The beneficiaries? We relied very, very heavily on community-based organizations. Even in the

good years when we were spending $2 million a year of general fund on marketing and outreach and advertising, that's a great broad brush stroke to have your Governor doing cute little television ads with children but really the most effective interventions, we think, are really embedded in neighborhoods and communities where neighbors and trusted people and trusted organizations come together and make a commitment.

That's why our enrollment has continued to go up even though we've pulled back every penny of general fund on outreach. We don't spend any money on that but by the time the economy got bad, the local foundations and national foundation work and community and faith-based organizations have really embraced this culture and believe, as we do, if the policy says you're eligible, we want you in the door and we want to provide services.

So there's this really, Aurora, Colorado is a suburb of Denver, one of the community-based organizations is doing a special outreach effort with Asian restaurants. It's a community that has a lot of ethnic restaurants and a lot of the

families that work in the restaurants and their children are eligible for programs.

So they came up with this very interesting targeted work to go into these restaurants and talk to the owners and educate them. So it's everything from that to enrollment fair, the traditional things where you go into a community but I would say that's really key for us.

DIANE ROWLAND: Tricia?

TRICIA BROOKS: I'm going to add to this from my experience as a CHIP director. The larger the percentage of uninsured the broad-based strategies do work. So some of those ads and getting the word out that these programs exist are really important. As you chunk down the number of uninsured, your efforts have to become more targeted. You have to really understand who the uninsured population is.

I ditto Joan's comments about reaching into communities and using community partners who have trusted relationship with families and that makes a huge difference but we would be remiss not to point out that many, particularly children, who are eligible have previously been enrolled.

For whatever reason, their families find it too hard to stay enrolled. They fall off the program. They have gaps in coverage and then experience a medical need and find themselves coming back into these programs.

So streamlining these processes are really important particularly at renewal but also at new enrollment. I've had families in New Hampshire make an attempt to apply on three, four, five occasions and just can't quite make it through the process because they are working three part-time jobs to piece a living together for their families and coming up with that last bit of paperwork is just really hard to accomplish. So the streamlining procedures are really critical for us to cover all eligible children.

DIANE ROWLAND: Okay, next question?

MARYBETH HARDY: Hi, my name is Marybeth Hardy. I work at the George Washington University Department of Health Policy.

Some of our funders are very excited about the opportunities that the Affordable Care Act brings in promoting preventative benefits under the United States preventative

Services Taskforce A&B recommendations and the Affordable Care Act creates some incentives for states to start offering those services.

So some of our funders are looking ahead to that and hoping to promote their services that they really care about, hoping that states will start to pick up on some of these screening and testing and other preventative services.

So I was wondering if Joan or Mary if perhaps you could speak about the likelihood that Ohio or Colorado or other states, what the likelihood might be that given these financial constraints that you all are facing that you might add additional, optional Medicaid benefits and whether or not the incentives in health reform are enough that states might pick up on these services and perhaps Cindy you could talk a bit about what the agency is planning to do to get states to pick up on that section of the act and to start offering those important and needed services.

MARY WATCHEL: I'll just say very briefly that it's really hard to speculate with a change in leadership and administration now. Ohio has done a lot of really good

planning and really good work to date. It's a little unclear where that will go but I will say talking with previous Department of Insurance officials just several months ago about that issue, I mean they acknowledged it would be a very heavy lift for a state like Ohio to consider doing that. I don't anticipate that would change given our new environment but that's speculation.

JOAN HENNEBERRY: I think that's true for us too although we do offer quite already some of the things that are being discussed and as we're thinking about our benefit design for our adults without dependent children program even prior to 2014.

We certainly are looking at primary prevention, early intervention as a way to make sure that the benefits package is what people need it to be but it really raises, I want to circle back to what Cindy said because it's really, and something Mary said as well, if this is really about public insurance being the health insurance plan, the ongoing health insurance plan for children in low-income families then we need to think about it that way.

What we have to do in the backroom to sort out the financing is very different than this continuum of services that we want people to get. If we want children to get in the door and stay in the door for not just a year but probably longer than that then we have to think about it the way we think about being in a commercial plan for several years where the plan and the providers actually have an opportunity to do something to help us get healthier. We don't want people in and out the door.

If we don't think about the policy that way, I think you have to think about the policy that way if you want to change the service delivery system, which is where all the waste is going on. So you have to marry up those two things and certainly an emphasis on screening and prevention and early intervention is going to be critical if we really want to save dollars in the system.

CINDY MANN: Yes, I'll just quickly echo that. That was exactly going to be my point. I think there's a tremendous amount of energy going on right now and we're going to be doing a lot of work with states over the next period of time on

really promoting better models of integrated care delivery systems.

So I think the energy and the interest is not just should we do preventive care, should we do substance abuse, should we do this benefit, should we do that benefit but how do we put together a service delivery system that really meets the needs of individuals because I think then not only are we going to better serve individuals but that we can get a handle on getting best value for the dollars spent.

So I think there'll be a lot of interest in that particularly in the context of integrated care delivery systems. I would mention although it doesn't certainly take care of all issues that for the newly eligible individuals coming into the Medicaid program starting in 2014, for three years, the match will be 100-percent financed by the federal government.

That'll make it easier and as you said, easier for states to think about their benefit packages and then there's a bump up in the match rate for states not getting the 100-percent for certain populations if they pick up the preventive

care. So there is a financial boost but I really think the energy will go in the context of thinking about how to do good integrated systems of care for people.

ROBERT PEAR: Thank you. I have a follow-up on the presentation by Miss Artiga. May I please ask if you could, a question on figure 15, the map of coverage of childless adults, could you go over the seven states or six states in D.C. that now provide Medicaid comparable coverage to childless adults and is that information in the table four?

SAMANTHA ARTIGA: It's a mix of states that have taken up the new option under health reform to expand early to adults. So there you have Connecticut and D.C. There are also some waiver states, actually the rest of them are really waiver states that have longer standing coverage programs for adults and have chosen to provide really the full Medicaid benefit package through those programs.

If you look on tables four and five, it'll break out both the authority through which the coverage is provided so you can see whether it's a waiver or state-funded program for those adults as well as the scope of benefits. So you can see

there those states that are providing the full benefit coverage. I would just also note that some of the states also have other programs that provide more limited coverage up to higher incomes than they provide the full Medicaid coverage for those adults.

So if you look at, for instance, Connecticut, they have the option to cover adults through Medicaid but they also have a state-funded premium subsidized coverage program for adults up to 300-percent of poverty that offers more limited benefits.

Hawaii provides full coverage up to 100-percent for which enrollment is currently closed but they have more limited waiver coverage that goes up to 200-percent and also some coverage options that are not shown in the table for previously covered people up to 300-percent of poverty.

If you look at Vermont, their VHAP program is their Medicaid benefit waiver program serving those adults. Then they also have Catamount Care, which is a more limited program that goes up to 300-percent of poverty. Oh you want the ones, the total seven? So the total seven are Arizona, Connecticut,

Delaware, D.C., Hawaii, New York, and Vermont. They're also labeled out in the full report.

ALICE WEISS: Hi, Alice Weiss from [inaudible] Maximizing Enrollment. I want to thank you for the expanded data in the report. It's very rich and I'm looking forward to digging in. I had a couple of questions because you had some new questions on the extent to which states are using the same system for multiple programs both other social, human service programs and Medicaid and CHIP and then you had some other data on the extent to which states are using data that they may have from other programs and not asking for documentation.

That led me to some additional questions about whether or not you were able to dig deeper and I know you asked a lot of questions but whether you're able to dig any deeper on the extent to which there's sort of more of a seamless approach, integrated approach between Medicaid and CHIP for the 34 states that use the same system for eligibility for Medicaid and CHIP and also the extent to which in those eight states that are using data and not asking for additional documentation at application.

What do we know about which programs they're sharing data with and what can that tell us about lessons for the future when we have to do more paper-free applications?

DIANE ROWLAND: Yes Alice, so I'm sure you want to get your hands on all of that data [laughter].

TRICIA BROOKS: We have some follow-up work to do I think trying to tie some of these pieces together and do multiple layered queries to say how many states do this also do this and also do that. Crunching these tables as they are over the holidays was challenging enough but we're definitely going to do some follow-up work in that regard.

I think what's really striking when we look at the states that have the capability to use systems to do administrative data matches; it is still astonishing to me that they haven't stopped asking for paperwork.

Now we understand that all states reserve the right that if the data that they have access to doesn't give them the information they need to make an accurate decision about someone's eligibility. They should ask for paper or more paper. Some of these private wage databases only report

earnings from say very large employers and don't give you earnings, for example, for the self-employed but it's interesting to look at the lag.

I know in some work I've done in Louisiana recently and we were talking about what happens when you finish the electronic application and you're ready to hit that button that says submit and it comes back and says we need from you the following documents and yet Louisiana's one of the most progressive states in terms of using those verifications.

So it's funny the lag that you see there and then you see that lag as it trickles out to parents but there's certainly more work to do. I think it's really; states go oh gosh we didn't go back and look at that application and realize that we didn't need to ask for that paperwork. So sort of a long and mixed answer to say we've got more digging in to do.

In terms of the kinds of databases people are using though, I will say we tested the survey instrument after making some changes on a few states and it really started to get complex in a lot of areas. We had to make some decisions about how much data we were going to collect and whether we could

actually keep state officials on the phone for four hours [laughter] and asking every possible question that we were really interested in. That's one of the things that sort of went by the way side is getting a full list of what those databases are.

JOAN HENNEBERRY: Yes, can I just point out too it would be very naïve for people to think that just building one big special black box computer program to determine eligibility for every program was the answer because it's not.

You have to think about the application itself, the software in conjunction with the business process that is used to get people's data into that system and if you try and fix just what's in the black box without adjusting the business process around it, who collects what, who submits what, what do you ask people for, how do you get rid of all of the paper shuffling and 64/88 counties?

That's then, you can have the most special black box in the world and it won't solve the problems if you don't address the business process at the same time.

MARY WATCHEL: If I could, I mean one of the issues that I've had to learn because sometimes we get Medicaid myopia and just look at folks as needing health care but we've seen a real migration of our caseload in Ohio where in the past we had seen, and I don't remember the exact percentages but a fair amount of kids having Medicaid only, now that's reversed.

So the majority of kids in our state have Medicaid plus whether it's cash or food stamps. So that's a shared eligibility system in our state, which is probably common in other states. So it may be tempting and on one hand easy to think about let's go in and simplify Medicaid but this is a system attached to other systems.

These are consumers who often have needs across the spectrum. So I think balancing continuing to move forward on Medicaid and preparing for 2014 and doing that across the spectrum is a real opportunity but huge challenge at the state level as well.

DIANE ROWLAND: We have a question in the back.

SUE ELLEN GALBRAITH: Sue Ellen Galbraith with ANCOR and my, it's not even a question, it's my plea to Diane and

thanks to Diane and all of Kaiser. Since federal officials can't lobby but they are in ear-sound of points, many of us, my name is Sue Ellen Galbraith with ANCOR, and we're private providers of supports to people with disabilities and we're very challenged to get the information, accurate information, to the states, to advocates, to state legislators, to governors.

As you may know there are some state officials in a new political climate that aren't as thrilled about Medicaid as many of us are. It's a data-driven world but we're dependent upon the data that is being driven by the political wishes at the state level. So it is extremely important for Kaiser to keep getting this information out and what other states are doing for cost efficiencies as we balance the need for the Band-Aids right now for budget crisis against the balancing with systems, real constructive systems change of the opportunities it can bring to Medicaid.

DIANE ROWLAND: Well I'd also say that this look is at eligibility and enrollment that affects children, childless adults, and parents but as you know, we also try and look at

what's happening with home and community-based services with some of the other aspects of the program. So we hear you. We have a question here.

DOUG TRAPP: Hi, Doug Trapp, *American Medical News.* This is probably more for Mary and Joan but with all the enrollment focus, are you also looking at whether or not these enrollees are getting care like tracking their access to care?

JOAN HENNEBERRY: Yes we are mostly for our kids, easier for kids because we have this major initiative around medical homes. So we track children's enrollment plus most of our kids, more of our children than our adults are in managed care plans.

We just have better access to information about them but through quality assurance reports, through the EPSDT reporting is probably one of the best ways that we use, HEDIS measures, CAHPS, all the usual surveys that states, just about everybody is using in their Medicaid programs to determine whether people are using the service but I think it was Tricia who mentioned or maybe Mary, you still do have this churn problem.

One of the problems we've had with presumptive eligibility is that families enroll when their kids are sick or have an emergency

and they don't follow through on the full application. So they're going on and off.

They're using care, using the financing mechanism when they need the care. So this is about getting coverage, getting the policy right, getting people in the door but there's a big responsibility around educating families about being better consumers on how to use the health care system in a way that would really advantage them and their kids too. So we have some work to do in that area.

MARY WATCHEL: I would say we're very similar in that we also have our child population and managed care. So that is the primary service delivery system and the way that those issues are monitored.

We do have some specific projects that the state has undertaken, for instance, with the managed care plans themselves to put an effort to getting more of the developmental screenings, make sure that more children have those on schedule.

We have some quality projects in place that are also working in indiscreet areas but I think it's a huge question and we all want accountability.

We all want to see that very clear path that coverage results in better health outcomes for kids. I think with the leadership, I'm thinking Cindy, of the quality measures that were included in CHIPRA and some of that being put into place as well moving forward that it'll give states tools, better tools, to answer some of those questions.

DIANE ROWLAND: Thank you. Well I think we've demonstrated today that there is a lot of variation in what's going on at the state level but that coverage matters but that in getting that coverage, the systems you put in place and the ways in which beneficiaries will interact with those systems are critical to translate eligibility levels into actual enrollment and coverage.

We've heard also that incentives matter, stability matters, and one of the stable things is that we have done this survey for 10 years and will continue to do it. We look forward to seeing next year all of you back here to hear what's changed and what's improved over the last year.

So thank you for being here today and thank you to our report preparers and presenters as well as to all of our panelists. Thank you very much [applause].

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.