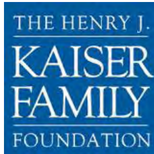

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Kaiser Briefing to Release New 2012 Data from 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Policies
Kaiser Family Foundation
January 18, 2012

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DIANE ROWLAND, SCD.: Silence comes over the room so it must be time to start. Welcome to the Barbara Jordan Conference Center and to the Kaiser Family Foundation, to this briefing on our next 50-state survey, the findings on Medicaid and CHIP eligibility, the enrollment policies. I'm Diane Rowland, the executive vice president of the Kaiser Family Foundation and the executive director of the Kaiser Commission on Medicaid and the uninsured and I'm very delighted to have you all here today to once again revisit where the states are and provide insight into their eligibility levels, their enrollment processes and their cost-sharing policies.

This is our eleventh annual survey so that we have quite a baseline for being able to follow what the states have been doing with their eligibility and enrollment over the years, to see the progress that has been made in terms of simplification of the eligibility systems and standardization of some of the eligibility levels. I think today's survey is particularly important because it's also a baseline for the implementation of health care reform in 2014 and it shows some

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of the progress that many of the states are making to try to move forward with new technology and new eligibility rules as they prepare for the implementation of health care reform.

It's also great to do this because with all 50 states participating we're really able to get away from the anecdotes of one state at a time and be able to really look at how the country is proceeding with implementing many of the changes in eligibility that underscore the move torward health care reform.

We also of course want to really thank the states. This is not easy to get 50 states to all participate in a survey to give you the kind of feedback we have and we appreciate with their budget constraints and with the time constraints they have that they're able to provide us not only with this survey but with the many other times we turn to them for budget information and other information.

Today we're going to be actually releasing two different reports. The first and most significant in terms of being able to provide you with data on all 50 states is our survey of eligibility enrollment, renewal, and cost-sharing

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policies in Medicaid and CHIP. This represents new 2012 data and identifies policy changes that occurred during 2011. We conduct this survey with Georgetown University Center for Children and Families and thank them for their cooperation and for working with us and Martha Heberlein, Tricia Brooks and Jocelyn Guyer they are primary authors joining with our Kaiser authors Samantha Artiga and Jessica Stephens. We do really again thank all of the state officials that allow us to make this a 50-state survey.

The second piece that we're releasing today we call Secrets to Success. It's an analysis of four states that are at the forefront of the nation's gains in children's health care coverage. It's a policy brief that looks at Alabama, Iowa, Massachusetts, and Oregon and look at the kinds of things they've done to achieve some of their success in enrolling eligible children. Again, we did that study in conjunction with Georgetown, Joselyn Guyer; Tricia Brooks and Sacantha Artiga from Kaiser were all participants.

We also include in your briefing packet a report that we recently released on ways to begin to look at performance

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measures under health care reform for eligibility and enrollment systems and we hope that that'll be informative in the work that you have going forward. Today we're going to turn first to try and lay out for you the findings from our 50-state survey and some of the insights from the success stories and then turn to a very distinguished panel. I'm going to start with Samantha Artiga and Tricia Brooks to lay out the study findings and then turn to a distinguished panel with federal, state and advocate perspectives. We'll start with Cindy Mann, who all of you know as the deputy administrator and director of the Center for Medicaid CHIP and Survey and Certification at the Centers for Medicare and Medicaid Services. Then John Supra has joined us from the State of South Carolina where he serves as the chief information officer and deputy director for eligibility and beneficiary services in the South Carolina Department of Health and Human Services. Then Dayanne Leal, who is the children and health policy and outreach manager for Health Care for All Massachusetts. We'll get an insight into the findings from the study and then we'll talk a little bit about some of the implications and where we

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go. I'm going to turn to Samantha to kick off our discussion and share with you some of our findings. Thank you.

SAMANTHA ARTIGA: Thanks so much for joining us here today. I want to follow on a couple of Diane's comments and just again recognize all the study authors, every single one of them made a huge contribution to the survey and it truly is a team effort that would not be possible without every person's contributions as well as wanting to recognize the assistance of Tara Mancini at Georgetown University who provided a lot of help with the effort as well.

To reiterate Diane's appreciation to the state officials who participated in the survey and took time out of incredibly busy schedules this year to share information with us and help us understand the nuances of their programs.

What I want to do today is really highlight some key overall findings from the survey and dig in with a little more details on the findings related to eligibility policies and then I'm going to turn it over to Tricia to pick up on some more detailed findings related to enrollment and renewal procedures and the growing use of technology among the states.

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But let's start with a few more details about the survey itself. As Diane mentioned this is the eleventh annual survey which covers all 50 states and the District of Columbia. It's based on telephone interviews that are conducted with Medicaid and CHIP program administrators and the survey questionnaire covers Medicaid and CHIP eligibility, enrollment, renewal and cost-sharing policies for children, pregnant women, parents and other non-disabled adults.

As was the case during 2010 during this year's survey we continued to track state adoption of options that were newly provided by the Children's Health Insurance Program Reauthorization Act of 2009 as well as some early steps related to state implementation of the Affordable Care Act. As Diane mentioned although data you will see here today presents policies in effect as of January 1st, 2012 as well as changes that occurred during the 2011 calendar year.

Before we jump in to the survey findings I thought it would be helpful to provide some context about the environment in which states were making their policy choices during 2011. There are a number of key factors I wanted to highlight. The

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first is that both families and states continue to deal with economic pressures during the year. Families continue to have a high need for coverage as job recovery remains slow. Similarly states continue to face revenue challenges. In addition midway through the year the enhanced federal funds that have been provided to states under the American Recovery and Reinvestment Act expired and those enhanced funds had helped states through the worst of the recession in dealing with increased need for coverage at a time of decreased revenues. Although the expiration of those funds was anticipated states still found it challenging because they were continuing to face budget shortfalls.

Also during the year the ACA requirement for states to maintain coverage remained in place. Under this requirement states must hold their eligibility, enrollment and renewal policies steady at the levels that at least at the levels that they were at the time the ACA was enacted and this policy was really designed to preserve the base of Medicaid and CHIP coverage in advance of the coverage expansions that will occur under reform in 2014.

As I mentioned new options and incentives that were provided under CHIP continued to shape state activity in 2011, and particularly of note in this last year was that CMS made a new time limited opportunity available for states to receive enhanced federal funding for major upgrades to their Medicaid eligibility systems. Specifically states can now receive a 90 percent federal match as opposed to the typical 50 percent administrative match for the design, development and implementation of major upgrades to their systems or new systems.

Then lastly the 2014 implementation date for the coverage expansions as well as really the overall new coordinated enrollment system for Medicaid and CHIP and exchange coverage drew one year closer.

Then jumping into the key survey findings. There are really a few key takeaway messages that I think we can get from this slide here, and the first is that reflective of the ACA requirement for states to maintain coverage Medicaid and CHIP eligibility had held steady in nearly all states during the year.

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Second is that even amid the state budget pressures that states were dealing with throughout the year 29 states made program improvements. As you'll hear from Tricia many of these improvements focused on using technology to help increase program efficiency and you'll also hear from her about the significant impact the new enhanced federal funding has had on state activities to upgrade their Medicaid eligibility systems.

The last point I would make from here is that even though they have the flexibility to do so few states increased cost sharing requirements for families during the year.

Then digging in a little bit deeper on eligibility findings what see here is that overall 11 states made targeted expansions in eligibility during the year. Most of these expansions focused on children, and those changes included an expansion in income eligibility for children in West Virginia from 250 to 300 percent of the poverty level as well as three states taking up the option provided under CHIPRA to expand coverage to lawfully-residing immigrant children without a five-year waiting period, and five states taking advantage of new flexibility provided by the ACA to extend coverage to

eligible dependent children of state employees in their separate CHIP programs.

In addition to those options for children three states also took steps to bolster coverage for low income adults through their Medicaid programs. This included Washington and New Jersey receiving Section 1115 waivers that allowed them to begin receiving federal Medicaid funds to cover low income adults they had previously covered with state-only dollars and Minnesota did the same through a combination of using the new ACA option available to cover low-income adults as well as a Section 1115 waiver.

You will see that two states did make eligibility reductions and these were done under limited exceptions to the ACA requirement for expiring waivers and specifically Arizona closed enrollment for childless adults, and Nevada allowed a waiver that covered about 150 pregnant women and a handful of parents to expire during the year.

With those changes what do we see with regard to children's coverage. I think what this map shows you is that Medicaid and CHIP across the nation remain a key source of

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coverage for low income children. All but four states now cover children to at least two in families with income to at least 200 percent of the federal poverty level and about half are covering at or above 250 percent of poverty.

This broad availability of Medicaid and CHIP coverage over the recent years has really protected children's coverage during the recession, and in fact the uninsured rate for children has fallen in recent years, even as child poverty rates have increased. As you can see here eligibility levels remain strong pretty much nationwide for kids.

Now the picture is much different for low income adults. As you see here their eligibility levels continue to lag far behind that of children. With regards specifically to parents you see the eligibility levels for Medicaid remain very low in most states, 33 states cover parents, limit eligibility for parents to below the federal poverty level and in 17 states they limit eligibility to less than half the poverty level, which is about $9,000 for a family of three during the year.

Coverage of other non-disabled low income adults is even more limited, and what you see here is only eight states

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provide Medicaid benefits to these adults. Additional states provide coverage that is more limited to these adults but in many states low income adults are not eligible for any coverage regardless of their income level.

Overall I think what these eligibility findings tell you is that states have made significant strides in covering children, however coverage options for low income adults remain very limited today. Given that the Medicaid expansion that will occur in 2014 to extend Medicaid to nearly all individuals up to 133 percent of poverty will significantly increase coverage options for these adults, many of whom currently lack access to private coverage and remain ineligible for Medicaid today.

With that I'm going to turn it over to Tricia to dig in on the enrollment and renewal findings.

TRICIA BROOKS: Good morning everyone. As Sam mentioned earlier of the 29 states making improvement 25 simplified their enrollment or renewal procedures. For the second year in a row the most popular simplification was documenting citizenship through an electronic data match with

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the Social Security Administration. Thirteen additional states implemented this streamlined way to more efficiently and accurately document citizenship for those that it is required for in Medicaid.

Eight states added new ways for families to renew coverage that don't rely on the old-fashioned paperwork process of mailing a blank form to them and asking them to fill it out and mail it back in with proof of eligibility. Six states adopted or expanded their use of express lane eligibility and five states added different functionality to their online services such as accepting electronic signatures or allowing online renewals.

We'll take a closer look at those actions in the next few slides but it's worth pointing out that some of the states that made changes made multiple changes, and in particular we highlight the activities of Georgia, Colorado and South Carolina on page 13 of the report who move forward on multiple fronts.

To a significant extent the new options and incentives that were introduced three years ago under CHIPRA continue to

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shape state activities in 2011. Since that Social Security Administration match for citizenship went live 44 states have adopted it. That's greatly reduced the paperwork burden on both families and states alike. While some states start with a single program or population generally states are extending its use to all Medicaid and CHIP applications that are subject to the citizenship documentation requirements.

Now a total of nine states have implemented express lane eligibility, SNAP, the Supplement Nutrition Assistance Program and state revenue or tax department are the most prevalent ELE agencies although a couple of states are exploring how to work with their diverse school lunch programs that tend to be administered under different authorities within a state.

In 2011 Georgia also launched the first partnership for express lane eligibility with WIC. Nearly half of the states now tap federal match to cover lawfully residing immigrant children. Sam noted the new states picking up the option this year but now we have a total of almost half of the states

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covering lawfully-residing immigrant children and 18 states doing so for pregnant women.

While some of these states actually leveraged federal funds to cover what individuals that had been previously covered with state-only funds this really helps to secure that funding stream which is really more vulnerable to budget cuts during down economic times.

Not noted on this slide but a key provision in CHIPRA that has contributed to states' improvement activities is the potential to earn Medicaid performance bonuses. The progression of states earning bonuses from 10 in 2009 to 16 in 2010 to 23 this past year is real evidence that the performance bonus has motivated states to introduce new simplifications in their enrollment and renewal processes. This year almost $300 million was shared by those 23 states and they received bonuses ranging from $1.3 to $28.3 million.

There's ample study that shows that churning of eligible individuals off and back on Medicaid and CHIP is administratively inefficient since a large percentage of individuals who lose coverage reapply within a matter of weeks

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or months. Churning also results in gaps in coverage that disrupt continuity of care and make it difficult to measure quality.

To address this problem states have been actively working to reduce churn by simplifying and expanding the options for families to renew coverage. Alternatives to the old-fashioned paperwork method include the use of express lane eligibility, telephone renewals, online renewals and administrative renewals. Administrative renewals are where states use a pre-populated form to send out to the family and if there're no changes either requires no action on the part of the family to maintain coverage or at most requires the family to confirm that they want to continue coverage and that often happens with a phone call.

As you can see from this slide with the exception of express lane eligibility roughly 40 percent of Medicaid programs and nearly half of CHIP programs offer each of these alternative renewal methods. But when you look at the bigger picture what you'll find is that the majority of Medicaid and CHIP programs offer at least one additional method to the old

paperwork method, and while a handful of them actually offer three the longstanding leader in retention, Louisiana, provides four different paths to renewal from Medicaid.

While many of the simplification measures are often introduced for children first over time states have aligned these procedures for parents in Medicaid with one big exception that you can see here and that's the asset test. About half of the states continue to consider a family's assets in determining eligibility for parents while most have eliminated the asset test for children. By 2014 all states will align these measures when asset tests and face-to-face interviews are eliminated and 12-month renewal periods and administrative verification of income will be the standard. However there may still be some inconsistencies as not all policies available for children are options for parents.

For example, neither 12-month continuous eligibility or express lane eligibility are options currently available to parents however we are beginning to see states seek waive authority to more fully align such policies. In 2010 New York received waiver approval to provide 12-month continuous

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eligibility to adults although implementation is pending system changes.

Very recently Massachusetts received waiver approval to use express lane eligibility for renewals for parents which will be implemented as a family-based renewal process through SNAP when the states children state plan amendment for express lane is approved.

As Sam noted states are advancing their use of technology and web-based services. Two-thirds of the state Medicaid programs and 80 percent of CHIP programs offer online applications that can be submitted electronically. A few of those, however, still require families to sign a piece of paper rather than accept electronic signatures. Most do use that application data to automatically populate or import into their eligibility systems although a handful continue to manually enter it. A large majority of the online applications do allow applicants to start, stop and return to the application to complete it and about two-thirds go a step further and provide additional functionality. They can accomplish other tasks such as checking their benefits, reporting changes or renewing

coverage. These online functions, along with verification of eligibility through trusted electronic data sources moves us closer to the vision for 2014 when enrollment and renewal will be streamlined and largely paperless and eligibility is determined in real time.

We note in the report that Oklahoma is the first state to operate such a system with 90 percent of the more than 1,000 applications processed each day receiving an immediate eligibility response even when state offices are closed. That gives us real hope that we can get there in 2014.

States are making progress in harnessing technology but the pace and scope of these efforts really must be accelerated if states are going to be ready in 2014. However, given ongoing state budget challenges, states have really lacked the resources to move forward toward this vision of a fully-automated paperless system. To help states prepare CMS approved the 90/10 rule that Samantha described earlier in April of 2011 and it provides much welcomed relief to states to move forward.

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There was little doubt that the enhanced funding would be a catalyst for state action but it was striking to discover in this year's survey just how quickly a diverse majority of states across the country have jumped at the enhanced funding opportunity to make sweeping changes to their Medicaid eligibility systems, many of which are decades old. States clearly understand that this is a time-limited opportunity to help them prepare for 2014. Three out of every five states either have received approval or have submitted the advanced planning documents needed to get approved for the 90/10 funding and all but three states indicate they're planning to move in that direction in 2012.

With those highlights of the data, let me summarize the overall key findings of the survey. Given the ACA's protection of Medicaid and CHIP, this report tells a much different story than at the end of the last recession in 2004 when this survey showed that 23 states made it more difficult to secure and retain coverage for children and families. While we expected states to maintain coverage, it was surprising to see that 29 states went beyond holding steady to make improvements through

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targeted expansions and streamlining their operations. Our nation's gains in children's coverage; that is achieving coverage for a record high of 92-percent of our children, is largely due to the strength of our Medicaid and CHIP programs. Unfortunately, coverage for parents and adults continues to lag far behind children while their uninsured rate continues to climb.

As Sam noted, although states did have flexibility to impose additional cost sharing on families, not premiums which are generally protected under the ACA, only six states increased copayments while four states actually decreased them. As discussed in a lot more detail, half of the states have simplified how they handle their enrollments and renewals often using technology to streamline and automate processes. The big news still is the large majority of states that have been approved or are seeking the 9010 funding to transform their Medicaid eligibility systems with only three exceptions. States will be busily working in 2012 to revolutionize eligibility using 21st century technology in ways that will make government work better and transform the experience of how

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families apply for and renew coverage. As budget pressures persist for states, modernizing how they manage enrollment and eligibility has helped them stretch scarce administrative resources and the ACA builds on their proven strategies; the strategies they've pioneered over years, while providing them with additional resources and clear timelines for implementation.

Considering that many of the state innovations in enrollment and renewal procedures were first implemented for children, we wanted to delve into what other factors contribute to our historic success in covering children. In this separate report, *The Secrets of Success*, we looked at the experience of four states at the forefront of our nations gains in coverage. We decided to focus on one state in each region. In the Northeast, the choice was easy; Massachusetts is the clear national leader in children's coverage with 99.5-percent of children covered. The other states were selected from all of the states that have made strong gains so we can't actually say that the selection was to identify the best per se. We examined recent gains in coverage and the adoption of

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enrollment and renewal simplifications and ultimately selected Alabama from the South, Iowa from the Midwest, and Oregon from the West. Although these states have distinct policy and political environments, there really are common elements of success. These include having political leaders who prioritize children's health coverage, expanding and maximizing those eligibility levels; each of these states cover kids up to 300-percent of poverty, adopting a broad range of simplifications, engaging providers and community partners in outreach application assistance and program monitoring, insuring strong coordination between Medicaid and the state's separate CHIP programs. Another common theme is that each of these states continue to address issues and look for ongoing ways to improve their programs and they share some common challenges in this regard; being able to manage higher caseloads with the diminishing administrative resources, finding ways to reduce churning and improve retention, working with those outdated inflexible eligibility systems that among other challenges make it difficult to improve client notices and to produce the timely performance data to identify problems and assess the

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effectiveness of changes, and last but not least, the challenge of making further progress through administrative and cultural changes while preparing for reform.

In closing, I also want to thank my co-authors and in particular recognize the state officials who really do spend an extraordinary amount of time with us getting the details right. I can't tell you how often we go back and say can we ask this just a different way. These are really challenging times for state Medicaid and CHIP agencies and we do appreciate their commitment to improving the health of our nation's children, families, seniors, and people with disabilities. With that I'll turn it back to Diane.

DIANE ROWLAND, SCD.: Thank you Tricia and thank you Samantha and now we'll turn to Cindy to offer some perspectives.

CINDY MANN: Great, thank you. It's great to be here this morning, so much better than what my usual mornings are so I appreciate it. I just want to recognize my fellow panelists first, Dayanne Leal from Health Care for All Massachusetts, the nearly 100-percent participation rate of eligible children in

Massachusetts is in no small part due to the efforts of Dayanne and Health Care for All so I'm eager to hear more about what she has to say. She's still always worried about getting that extra 0.5-percent so we love her for that. John Supra and his colleagues in South Carolina also deserve a really special callout. South Carolina was one of the states this year that was a first-time earner of the performance bonus that Tricia spoke about earlier today and has just adopted express lane eligibility that we've heard a little bit about so congratulations to John and we're eager to hear more about what they're up to in South Carolina. Much thanks, of course, goes to the Kaiser Commission on Medicaid and the Uninsured and the Georgetown Center for Children and Families for doing this really invaluable survey. As Dayanne says, having 11 years of this survey provides us with just invaluable information of the trends of how we've been doing in coverage as a nation over the last decade. Beyond that, each year the survey gets a little bit richer and provides a little bit more information in a different area so we're always learning more as we go forward so we really want to thank you both for the very detailed

survey and the enormous contribution that it makes to our body of knowledge.

We're of course all very excited to see this year's surveys results indicate that states have maintained or even expanded improved coverage for kids and for families despite some very significant challenges. I think there's little doubt, and if you look at the survey for the last 11 years, it just confirms that certainly coverage is a national priority and without doubt the issue of children's coverage is a shared priority across the nation regardless of political climate, regardless of fiscal challenges, and Samantha if you want to put up the slide, and here's why. This is Marilyn who's 12 years old, her sister Nancy who's 4 years old, and they live with their mom Carmen in Iowa; we've heard a bit about Iowa. They moved from California. They moved to Iowa to work with Carmen's fiancé's family who has a budding bakery business, I practiced that, and like many people working in small businesses they work hard and they don't have health insurance. Nancy needed dental work, went to the local Department of Health, there's a maternal and child health clinic, dental

hygienist was working with the family and learned that they were uninsured and said we've got a program for you and we've even got presumptive eligibility, which means that the family, the children could get enrolled in coverage at the clinic that day. That's what presumptive eligibility does; it allows for families to get on coverage if they appear to be eligible at a community-based site that's been certified by the state and then they can get their coverage quickly and efficiently. I'm told, I can't quite see the red, but I'm told that Marilyn's red glasses are a product of finally having coverage and finally being able to get a vision care test, which she hadn't had for too many years. She got new glasses and they're spiffy red, so that's really what it's all about. That's really why we all work on these issues and why we care so much about moving forward.

Making sure that every child who's eligible for Medicaid and CHIP is actually enrolled in the program is a real top priority of this administration and of Secretary Sebelius and of course, as we see, of the states. The Secretary has traveled around the country and issued to governors, to

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community based organizations, to mayors, to faith-based organizations, and certainly to those of us in the department that we shall have a challenge to cover every single one of those eligible children and make sure that they're enrolled and it is formally called the Connecting Kids to Coverage Challenge. The challenge has not stopped at the doorsteps of HHS. Last August, the Secretary involved Secretary Duncan and together the two secretaries wrote all the superintendents of schools across the country to talk about the ways in which schools and Medicaid programs and CHIP programs and community-based organizations can partner together to make sure that all eligible children are enrolled and stay enrolled.

The work is also embedded deep in America's communities. Just last August, also, we released $40 million dollars in CHIPRA outreach fund grants to dedicated efforts to find, enroll, and retain kids in Medicaid and CHIP and apropos Tricia's comments in this year we prioritized a number of areas, around school based areas but also around technology really trying to invest in technology and see about ways to modernize our systems of outreach enrollment and retention.

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The grants were given to 22 organizations in 23 states and it follows grants that we issued in 2009 that were provided to 68 grantees in 41 states. I will say every one of the states represented in *The Secrets to Success* reports have grantees in their states and in one case the state itself is a grantee so we'd like to see that these grants are really making a difference in people's lives.

Just last November under the banner of the secretary's challenge, we had our grantees and some of their closest friends about nearly 500 people all together met in Chicago to talk about lessons learned over the last decade or so in terms of improving coverage and sharing ideas, sharing strategies, and most excitedly making plans for continuing to move forward. State progress in this area, which is so well documented in these reports, is also demonstrated by the performance bonuses that we announced at the very end of 2010. As Tricia noted, we announced 23 states had earned bonuses this year, up from 16 states last year, up from 10 states in the first year, in 2009 when the bonuses were awarded. As I've mentioned, South Carolina is one of those states that were awarded a bonus. The

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bonuses, the annual bonuses, really demonstrate substantial gains in Medicaid enrollment. It's not just because a state has done this program feature or that program feature and has adopted certain changes, they have to adopt those changes as a prerequisite, but they also have to actually boost enrollment of Medicaid children of the lowest income children and it is only when they do both, adopt the simplification measures and actually are successful in achieving significant enrollment gains that they earn the bonus.

One of the most heartening things beyond the fact that we keep seeing more states qualify for bonuses over the years is that we see states that have qualified for a bonus continue to improve their programs and we see that documented in our analysis of the performance bonus quality features and we certainly see that documented in the report that we have today. It acknowledges, the bonuses acknowledge not only the good work, but it really also helps to diffuse the practices over the country and we like to think of these simplification steps as the gift that keeps on giving because it doesn't just affect enrollment the year that the state gets the bonus, but week

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after week, year after year these simplification measures continue to help families like the Lopez family be able to access coverage. Let me conclude by making two points; first, following the leadership of Secretary Sebelius and certainly the President who signed the CHIPRA Law, one of his first acts coming into office, CMS is really here as a resource to states and others wrestling with these challenges and trying to find new ways to improve their systems. There are tried and true methods that we've seen over the years continue to work as states adopt them and perfect them for their local circumstances.

There are also new ways of doing things and as Tricia mentioned we've provided waivers to New York, waivers of authority to New York and Massachusetts to take some of the simplification measures that are statutory options for children and applied those on a family based way of continuous eligibility and express lane. Second, I want to note that the kind of progress that have been chronicled for kids over the years through these Kaiser surveys provide us a roadmap for successful implementation in 2014. I would refer you back to

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looking at Samantha's slides six and seven. They show, in 2011, in 17 states a parent with earnings just at 50-percent of the poverty line, which is $9265.00 dollars a year or just a little over $800.00 dollars a month for a family of three; that parent earns too much to qualify for Medicaid. That will change in 2014, as will the fact that other adults, those whose children have grown and left the home, those who don't have children, any adult who's not otherwise disabled, pregnant, or elderly, those adults can qualify for Medicaid in more than half the states no matter what their income level is. That again will change in 2014.

But, as we've learned from the states that have been leading the way the coverage expansions alone aren't sufficient so we need to simplify the processes, we need to coordinate the system across programs, and we'll have even more options in terms of programs available, of course, in 2014. We need to really focus on technology and modernization and of course good old-fashioned outreach making sure people know the opportunities that are available. We hope to take many of these important lessons that are learned from the state efforts

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in children's coverage to lay the groundwork for 2014 and really thank the Kaiser commission on Medicaid and Georgetown Center for Children and Families for all your help in providing us this guidance.

DIANE ROWLAND, SCD.: Thank you Cindy, John.

JOHN SUPRA: Thank you; it's a real pleasure to be here and to share some of the experiences in South Carolina. Like Cindy, I really do want to thank the Kaiser Foundation, the Georgetown Center for Children and Families for their work that really sets the groundwork so that we can measure the progress that we're making. For us in South Carolina, it is really an exciting time to be active in improving the coverage and access to care for children and their families in South Carolina. I really have to look at *The Secrets of Success*; one of those key elements that was talked about is a real strong support at legislative levels for coverage for kids. I think for myself, very fortunate to step into an environment where the legislature had recently expanded the coverage limit and also directed us to use technology or other tools that might be available to insure that coverage. I think those two things

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that are really a statewide initiative set the groundwork for both our new director Tony Keck as well as myself coming in and saying where are we and what progress has been made.

In March, we looked at what simplifications had already been done? What was available and knowing the pending deadline of April 1 what could we do? I think one of the things that our administration in Health and Human Services is very focused on is how do we look at process improvement, the use of technology in measurement driven decision making and I think in Tricia's portion of the presentation she talked a lot about what have they seen across the states. I think many of those things are what we looked at pretty quickly in March to say we'd already met four of the criteria, what available criteria was left that we could reasonably make, and what is the data around that to make a decision. Looking at the goals or the incentives of the bonus program, we asked the question of what do we know?

What we found out is, and I think what many states have found out, in our children we had a tremendous churn, we had about 140,000 kids churning out of the program every single

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year, 90,000 of those return to our programs within the year, and 60,000 of them return to our programs within one month. The average time out of our programs were about 1-1/2 or 1.4 months. What did that say to us? What we were really doing is creating an awful lot of administrative hassle for our families, for our staff, and for our provider networks who often are caught in the middle of this. We also look at the total cost of keeping those children enrolled because we have retroactive eligibility back to 90 days so we're paying for a lot of this cost already. I think a big element was we were able to look at the data and say express lane redeterminations made a lot of sense based on the data and we looked and said can we act quickly and qualify or meet those incentive timelines. I'm excited the team we had was able to look at the data, find a way to act quickly, and then implement a redetermination program taking our SNAP and TANF data. I think it really does show the transition we need to make collectively in South Carolina and I think in other states about looking at the data, understanding what we're doing and why we're doing it in making decisions that are highly data driven.

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As a result of what I believe is a real success, we've now re-determined and re-enrolled about 80,000 kids since April 1st, averaging about 9,000 a month, which is about in line with what we would've expected. We then moved forward to look at how do we take the remaining kids that we know are in the SNAP and TANF Programs and look at express lane enrollment program in a way that's fiscally responsible and that the state can afford. We proposed in our budget, and our governor's executive budget was released last week, and she supported our efforts to move forward in the next fiscal year with express lane enrollment. Again, it makes sense, it is administratively prudent and it provides access to coverage for those in the most need. We also believe it's a very important step in preparing for 2014 and the Medicaid expansion that isn't a current law, is it gives us experience enrolling large numbers of people at one time. We expect somewhere between 70- and 80,000 kids exist at any given time in the SNAP and TANF roles and it prepares our provider communities, our community partners, for the experience of how do we take these people

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into the program, get them the coverage, get them the benefits, and insure that they start utilizing services.

We're looking forward to that. We are entering our legislative session in the budget process, but we're hopeful that we'll have the opportunity to extend, as I think the research has shown, many of the states continue to extend their programs as we look forward to 2014. We heard a lot about many of the states that are undertaking eligibility enrollment and other technology changes that are going to be both required, helpful, and really made possible through CMS's enhanced funding in the eligibility enrollment systems. But, as probably more a technologist than definitely a Medicaid person the technology isn't a silver bullet alone. What I see and what I encourage both my supervisors and our frontline staff in other states as I talk with them is we've got to look at process improvement. When we look at express lane eligibility it's not just the technological ability to make a match and stop there and make the enrollment decision, it's what do we need to do next and how more importantly do the processes in work that our state staff and our community partners do to make

sure that the next steps are taken. We move out of the way the paper processes, we move out of the way sort of the requirements to check the boxes, and we have to move to the forefront a set of processes that insure not just access to care, not just access to the coverage, but utilization of the services.

As we look forward, we look at the benefits and the opportunities of replacing our aging mainframe eligibility system as critical to the more important goal of process improvement. How do we look at the whole process, how do we streamline those processes, and how do we take technology and measurement driven outcomes as important goals in that effort? I think in really summarizing that, I think that Cindy’s example of the Lopez family is a great success story. How do we bring those success stories across the board, how do we insure and start to measure and move our discussion beyond where we’ve had a lot of great success in bringing coverage, we need to continue that discussion. That’s not going to stop, but I think it’s time for us to move towards how do we measure the utilization once we give access to coverage, and then what

are the outcomes to building healthier communities. That is our next step as a broad community because when I talk with pediatricians, our practices, we ask the question of if we are able to cover and get access to this large population in your community; are you ready to absorb them? How do we start to understand how the healthcare access leads to healthier communities? We're very excited in South Carolina, we're absolutely thrilled about the opportunity to be both here talking with you, but also really on behalf of the citizens to earn the bonus that shows we're taking the steps in the right direction and we look forward to continuing those steps really focused on health outcomes and the changes that we can make in the community level as we move forward. Thank you.

DIANE ROWLAND, SCD.: Thank you John. Dayanne.

DAYANNE LEAL: Sure, good morning. That's a lot of pressure on Massachusetts, like wow. Thank you Cindy Mann, but I think I cannot take all the credit and Health Care for All cannot take all the credit. We definitely cannot take all the credit, but it's true that I am committed in trying to find that mainly little kids and big kids too, because I think we

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need to always remember that it's also the young adults and the older children that's also a part of the group that we're trying to reach. You have wonderful reports so everyone else I would like to thank you too, the Kaiser and Georgetown, so thank you very much and thank you very much for the opportunity for being here. I'm going to spend a brief time looking at these wonderful reports, I'm not going to spend time giving the details on the policies we've implemented or did not implement in Massachusetts, but I want to give you a little bit of flavor of the community work that has happened in Massachusetts.

I think I want to start us off by really putting out there the message that we can do it. Okay, so again, we can do it. We did it in Massachusetts, we did it for kids. Tricia already mentioned the number; 99.5-percent is the results. This is really a representation of the number of kids we were able to reach in Massachusetts. I think I want to share a little bit with you this morning what are some of the ingredients to how we were able to accomplish that. The secret to success is that recipe that your grandma keeps for herself, just kidding; other states are already using it. It is not

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that secret anymore, but I want to start by saying that in Massachusetts we had a top-down, bottom-up approach so it was very important to have a broad awareness campaign. It was very important to involve the paid media, earned media, advertising, and the assistance in place that we were able to accomplish in Massachusetts, the policies that we were able to advance, but also it's really the bottom up and what I mean by that is really the community. It's that people are working in their different work places, people are leaving different neighborhoods, people belong to different community groups, people go to church, synagogues, go to mosques, they take their kids to schools. They are really everywhere and I think we cannot miss that important piece that is people really helping other people to connect to health insurance, but also to care. Thank you for that point. I think it is important to remember that having an insurance card does not always translate into access and coverage and I think in Massachusetts the role of community-based organizations in helping people to navigate the system really, really, really works.

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It's important to remember that in Massachusetts we have a very diverse group of individuals so each community really did it their own way. I think each community has their magic way of reaching out to the people and helping them to access to coverage. It ranged from people set up a table at a mall, people setting up a table at a church fair, going to do presentations at a school, the western rural part of Massachusetts literally this really happened, one of our community partners there placed a sticker on their local newspaper that said are you uninsured, give us a call. It's very personable, it's really that one-on-one so just pick up a phone and I'm going to help you and that's really what we do at Health Care for All. We have a helpline and we help them to sign up over the phone so it's very easy for people. They don't need to miss a day of work to go somewhere to enroll. They just call, and we help them to navigate that very complicated process to some people.

I was almost forgetting that another great way that is bottom up that also worked was working with the local ethnic media. I have been going to several radios to target the

Brazilian community. I have been doing this work four or five years, so I was able to witness the successes that Massachusetts had. One of the key successes for Health Care for All was me going out to the radio program and talking to the Brazilian community. The Brazilian community was key in Massachusetts. I will be bold and say Portuguese is the second most spoken language in Massachusetts, then Spanish. A lot of people don't believe me on that, but I can prove. One of the ways, and I am Brazilian, I also realized the large community that was there, every time I would go to a radio and I would give the phone number, our phones would not stop ringing, literally would not stop ringing. There is one thing I want to say, don't do it. Don't give your cell phone on the radio [laughter]. What was I thinking? Anyway, all to get those kids enrolled.

I think that one secret ingredient is creativity. I encourage creativity. I think being creative in these tough economic times really helps us a lot, and I can give you two quick examples that we did at Health Care for All. One was a phone-a-thon where we just put it at pressure time. We told

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families you have one day to enroll your kids, so on September 29, people are like crazy calling thinking that was the only day. I felt bad, but honestly, it worked. We had 405 people calling us in one day. Can I enroll today? The second thing was a fun challenge that we did in Massachusetts. We challenged all these states to really increase their efforts and enroll as many kids as possible in one month. We had a goal of 500 kids; we enrolled 1,479, great, so creativity.

The second ingredient is the essence, so we had the approach, and now it was the essence. The essence of our work is one very simple and complex word, partnership, and we were successful because of the relationships and the partnerships that we were able to develop and maintain in Massachusetts. One very special partnership is the relationship between the state and the community-based organizations. First of all, the state provided funding through 51 grants to help them to enroll, so that alone is big and key. Why? Because you are maximizing your potential to really enroll people but also to be able to provide culturally appropriate service in different, multiple languages that the state alone couldn't do.

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It's important and it's very clear to us in Massachusetts that it is a two-way street. I think that this notion of two-way street works in many parts of our lives. You give something, you receive something, and it is like always an exchange. The fact that the state is providing the support to community-based organizations and the community-based organizations are providing the support back to the state has been very, very important. One thing that the state does for our organizations is providing training and updates on a quarterly basis, so we're always aware what the policies are and the provisions changes that are happening on a regular basis. But also we serve as the cannery—am I saying that right cannery or canary? What is the bird?

MALE SPEAKER: Canary.

DAYANNE LEAL: That bird [laughter]. Which means we are always spotting glitches and letting the state know what's working and what's not working. It also goes to that level of partnership. We proofread and provide edits to documents before the state sends them out, so big, big partnership there. The other precious partnership is with the diverse stakeholders

that really allow us to accomplish this amazing number of 99.5-percent which are the other partners that A, are doing similar work that we're doing in Health Care for All, and B, are also just helping to get the word out. I think Cindy may have mentioned the old-fashioned outreach, making sure that people get information. Working with the doctor's office so they know which options are available to people, working with the churches, working with the schools, working with employers, so working with a variety of people in building this strong stakeholder partnership has really been integral to our success.

Third and final ingredient is the catalyst, which is money. We need substantial final resources to do this work, and we were able to do this work in Massachusetts because we received state money, federal money, and also funding from private foundations that supported this work. This work is not for free, but it is important and it pays off, so I think it is important to remember that Massachusetts is doing so well, but if we stop investing we're going to go backwards, and we do not want that. I think it's important to really reiterate that all

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states need the money to continue the work that they are doing, and we heard that many states are doing great work as well.

Moving forward, the work doesn't stop once you get them enrolled. What we learned in Massachusetts is that it's hard work getting kids enrolled, even harder keeping them enrolled, so we need the systems in place in order to be able to do that, and I want to thank Cindy for approving our waiver in Massachusetts. It's going to help us do more, greater good things when it comes to coverage retention, that's going to be key for us, so thank you so much. We need to continue to involve people in that process of coverage retention as well.

To conclude, I will again say we need to have systems that work. We all agreed that we need to have technology in place and use technology in a smart way, but it comes down to people. If we don't have that one-on-one conversation that happens over and over and over, it's going to be hard. People, talking to some people in the community, absolutely love and appreciate when you give them a 17-page form for them to fill out, they go, I don't think I can do that. I think we need to help them to navigate that particular process.

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We embraced, in Massachusetts, three words and encourage that we continue to embrace that. One is choice; we made the choice to provide services to kids and coverage to kids, commitment to do that work, and creativity, as I mentioned before. If I can just be a little bit bold, if we are able, can you please stand up if you are an advocate? Can you please stand up if you are a policy analyst? Remain standing; I forgot about that little direction. Can you please stand up if you're a member of the media or the ethnic media? Can you please stand up if you care about children's health? I want to see everybody standing, if you may [laughter], to say that it's because of people like you that we were able to do the work we did in Massachusetts, and we need people like you to do the work that we need to continue to do to get where we all want to get. Thank you so much and thank you for playing and standing up [laughter].

DIANE ROWLAND, SCD.: I think there should be no doubt that she's going to get to 100-percent [laughter], and I think this clearly demonstrates that while we can have lots of statistics in the report about steps and processes and changes

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in income levels and eligibility, that what matters is what happens on the ground in the leadership that the people on this panel and others out there are demonstrating in their commitment to getting kids covered.

With that, we would love to have you ask the panel more about what they do and how they do it or about some of the findings from the survey. If you would please raise your hand so that our people with mics can find you, and then identify your affiliation and name so that the panel knows who's asking them a question, and if you prefer to direct your question to a particular panelist, please do so.

JOSH ROVNER: Thanks for a great event. My name's Josh Rovner. I'm with the National Assembly on School-Based Health Care, but I'll try not to make it too selfish a question. I'm curious about the experience from Massachusetts. Now that we have so many kids enrolled, I'm curious about act two. How well is it working to save money on the backend? How well are you keeping kids out of emergency rooms and getting the primary care that the kids need? My selfishness in this is that school-based health care is a great way to get kids to the

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doctors and nurse practitioners, but is it working in Massachusetts? Now that they're enrolled and have eligibility, are they getting the care that they need, and is the cost savings emerging?

DAYANNE LEAL: Great question, so two things, one is that as far as the cost savings, I want to say that we are now moving towards phase two. We had phase one back in 2006 with our own health reform, and right now we are in the process of working towards another reform, which is around payment reform, so that's where we hope to save cost.

As far as the school-based health care, school-based health centers, I wanted to say that we also partner with them and we value the work. It is always a challenge for the schools. They don't have enough staff, even the nurses, to be able to provide the immediate care that kids need, and I don't think I have an answer to the full question. I think it is a challenge that we also have in Massachusetts, but I think the important thing is that we have two things on the radar. One is cost; we need to do something about cost because it is not sustainable, and number two, going back to my point of

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partnership, understanding that other places play a crucial role in making sure that kids are connected to care.

Finally, the role of community-based organizations in general, I think we don't only provide the enrollment assistance and make sure that they have a card, but at Health Care for All, for example, they're constantly calling us and asking for help to connect them to a provider, to connect them to a dentist. It's very hard to find dentists. It is sometimes a waitlist to find, but I think we are trying to do that better and better, but it's a challenge.

MARISA SCALA-FOLEY: Good morning, Marisa Scala-Foley with the Administration on Aging. First of all, thank you. This briefing has been terrific. My question is primarily for the study authors, but also I'd love to hear from the states on this. While I know your focus was primarily on children and low-income adults, I wondered if you got any sense from your survey of the extent to which any of these administrative simplifications have been extended to other populations such as older adults or younger adults with disabilities.

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SAMANTHA ARTIGA: In this study, we focused on the nondisabled and nonelderly populations, and most of the folks we were speaking to in the state administrations deal solely with those populations, so I don't feel like we have a good sense of that from this work. We do have a number of other efforts underway in the foundation exploring what's going on for those populations, so I'd be happy to connect afterwards and direct you to some people and resources that can help you.

JOHN SUPRA: Speaking on the state of South Carolina's behalf, I think we see the simplifications, not necessarily the policy, but as we apply technology, as we apply process improvement, we're lockstep in with our long-term care, our other programs, so we see some of the opportunities here that are driven through the CHIPRA programs as ways to pilot or test things that are good for all the populations. I see that as how it'll play out in our state.

MARY MOSQUERA: Hello, I'm Mary Mosquera with *Government Health IT* and *Health Care Finance News*. I'm especially interested to hear from the states. As you said Ms. Leal, that you have to keep on investing; we can't stop now.

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Have the states prepared or made some type of thinking ahead if during the Supreme Court arguments, when the Supreme Court decides about the health reform law, if they decide that the Medicaid provision will not stand, how will that affect states? Because you're so far invested already in preparing to cover a whole lot more people and especially with so much funding coming from CMS federal funds to help with your simplification and with your systems, how will you go forward? Have you prepared, or has the legislature talked about it? Because that could happen midyear, have a real effect.

DAYANNE LEAL: Let me see if I understood your question, if we're prepared to take on the kids or you're talking about if the funds are not there after?

MARY MOSQUERA: Yes, if the funds are not there or if there is not the drive because that provision has been struck down from the law, have you thought about what states will do? Or will you continue as you have been anyway because you're so far into it that you're going to keep going because it's in the state's best interest?

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DAYANNE LEAL: First of all, there's the financial issue; it's already here. We, as advocates, are also advocating for funding for our administration, so just recently, we had a meeting with the Office of Medicaid and making a decision that one of the coalitions of Healthcare for All we wanted to advocate for more funding so then they can pay for administrative staff. I think staff is always an issue. How can you make sure that you can, on the backend, be processing all these cases?

The other thing is I think we already have proven that we are committed no matter what. We have made this commitment to help kids for so many years; we already expanded our coverage so many years back. We have 300-percent of the federal poverty level, so there is a commitment. But there is a shift now, which as I mentioned before, we need to be creative and smarter on keeping kids covered, and I think we can have some savings there. We haven't been able to quantify how much that would mean, but we know there're tons of notices from Mass Health, our Medicaid and CHIP in Massachusetts. The tons of notices that they send to families when they fall off

of coverage, despite the fact they're still eligible. I think it's a shift now on we got this far. We were able to enroll these kids. Now the next step for us is making sure they keep covered, and we'll find a way. We are going to be faced with a challenge next year because the 51 grantees are no longer going to be receiving state dollars, so this is a challenge for us. The commitment is going to help us to hold on through this rough tide, hope for better days.

DIANE ROWLAND, SCD.: Trish, you had a comment, then John.

TRICIA BROOKS: Yes, none of the lower courts have struck down the Medicaid expansion, and so I think it's unlikely, although I'm not a constitutional lawyer, that that will happen. I will say that the transformation of technology is long overdue. States have been putting band-aids on these decades old mainframe systems to get by, and they are crippled in having the kind of data they need to make sure that their programs work more efficiently and are hitting the mark. I would hope, even in that outside chance that something might happen, that we would continue to see the investment in

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technology. These programs are not going to go away. They've been highly successful, states have been making incremental gains along the way, and they need the technology to back them up. I hope that the federal support will stay there no matter what.

DIANE ROWLAND, SCD.: John?

JOHN SUPRA: I was going to talk about kids' coverage and then the systems, but I'll continue what Tricia started. The systems we have in South Carolina, and I think in many states, do need updating, and updating them will make for more efficient government. Regardless of how things go, as long as the enhanced funding and the alignment that eligibility systems and MMIS or the claims processing systems are funded in the same ways as what CMS did last year, there's no reason in our state, and I think in many states, we would stop that movement forward because it's good for process improvement, and actually, very good for improved and more efficient government. In South Carolina, the programs that I spoke about, and including our express lane efforts that we have in next year's proposed budget, are to cover those people already eligible but

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not yet enrolled under our current laws. Currently, we're able to run these programs to these coverage levels, and we've been instructed in legislation to use technology to do this. The way that we've approached this is there's a lot of uncertainty, but the things that we're doing are either based on the current laws and technologically good under all circumstances, and I would hope many states see things in a similar way.

DIANE ROWLAND, SCD.: Samantha. I'm not going to make Cindy comment.

SAMANTHA ARTIGA: I want to echo John's comment. I think all of us who conducted the interviews for the survey this year would come away with the feeling that the improvement we were seeing, especially on the technology front and the decision to take up the enhanced funding, was just as much about improving current program operations and not necessarily so focused with the goal in preparing for reform. As Tricia mentioned, I think states have long been frustrated with the limitations of their current systems, and John, frankly, I think many states would be jealous that you have access to the kind of performance data now that enabled you to identify where

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you were having problems and the types of policies you could put into place to solve those problems. I think a lot of the technology improvements picked up in the survey are about states dealing with current program operations and trying to use scarce resources as best possible and using the availability of the federal funds to support those efforts.

DIANE ROWLAND, SCD.: Next question?

KATHY KUHMERKER: I'm Kathy Kuhmerker from the Association for Community Affiliated Plans which is a member organization of safety net health plans across the nation, and first I wanted to thank you again, as many others did, for a wonderful report and for many, many years of wonderful reports. I also wanted to follow up on a comment that one of the panelists made and then one of the earlier questions about some of the simplification efforts that are available now for children but that aren't available for adults, and in particular, the issue of continuous eligibility. We can see from the report that 12-month renewal periods are very helpful, but they clearly have not managed to make a full dent in the amount of churning that goes on. While I think there are a

number of groups and organizations that think we can get to continuous eligibility without an additional statutory change, if that is something that is required, I'd be interested to hear from the panel about what kinds of arguments do you think would help to sway legislators on a state or national level that this is important and that continuous eligibility for everyone on Medicaid and CHIP is an important factor and a way to make the programs run well.

TRICIA BROOKS: We can't measure quality of health care and outcomes unless we keep people continuously enrolled, and even in states like Utah, the legislature is talking about 12-month continuous eligibility, and that's being prompted to a large extent by the insurers who are pressured to produce proof that the dollars invested in what they do matter. I think that's the most persuasive argument, and the proposed rules for the Medicaid expansion do take a little step forward by allowing states to look at whether a change impacts eligibility overall going forward toward the end of the year, not quite as far as I would have liked to have seen it go. But I hope that we'll see more states realizing the importance of aligning all

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of those policy options in doing what New York did in seeking waiver approval to do that, but I do think the quality of care and the measurement is a key piece there.

DAYANNE LEAL: Can I add one quick thing? I think in Massachusetts, we have seen that kids and parents go together. Health reform, we had one date for adults to seek coverage but not kids, but saw that that had a reflection on kids accessing coverage, so I think they're very integral. In Massachusetts, also we believe that we should do policies for adults as well, so our waiver, again thank you, will also be for kids and adults. The continuity of care is important, and I think that the combination of what you can do at the grassroots level and also a policy like the express lane renewal, for example, that can make a difference. I want to quickly say that in Massachusetts we did this effort of providing magnets to remind families that they need to open their mail because I think that is a big problem, very important to open. If you're already with a lot of problems in your life, you're going to be oh, my gosh, one more problem. You're not going to open, and then also bookmarks that help them to learn or be aware of some tips

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that they can do to make sure that they keep coverage, and that's for adults and kids. I think there are some efforts out there that can help us move in that direction.

LINDA HOMBERG: Linda Homberg from the Maternal and Child Health Bureau, and Cindy, I want to thank you for pointing out the role that the Title V Maternal and Child Health Agency played in Iowa in getting the family coverage and enrollment. I'd like to hear from the other panelists the role that Title V has played in terms of outreach in working with women and children not only to get enrolled in Medicaid and CHIP, but also in quality improvement in providing medical homes, and in outreach services. Thank you.

JOHN SUPRA: I think the coverage available, particularly with regard to pregnant women in a number of other programs, and when we talk about what it means to look at health outcomes, we believe that starting early in the pregnancy in insuring a healthy pregnancy, being able to get simplification with regard to enrolling the children of enrolled mothers, and then looking at that immediate care is what's going to guide our overall outcomes. Again, we have a

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number of more medically focused programs. We have a birth outcomes initiative which we're looking at preterm deliveries in our OB/Gyn communities, and we're also looking at a program that's called SBIRT that looks to identify potential problems or issues with substance abuse or other problems within the household to lead to the outcomes for healthy delivery and then healthy children. We do believe that it's a continuum of care that starts with the pregnancy and I think those programs have enabled us to think about it that way.

MALE SPEAKER: [Inaudible 01:23:00] Hudson Institute. Question for John Supra, as a technologist, you have 23 months to jump 23 years in systems. Give us a stronger, more detailed sense of what it is that you need to accomplish in that period of time.

JOHN SUPRA: Putting on the technologist hat, I'm going to talk about this in three ways. One is my background and experience is primarily driven in building large Web-based applications which, in general, are built, and the three terms that I use with my team are agile, iterative, and incremental. What I mean by that is we need to move a lot more quickly. We

need to be able to make decisions, start implementing technology, get it mostly right, and understand that we can iterate over it.

I've looked at a lot of ideas, both process as well as technology, that have existed in our department for many years. What they are, are big reports that could never get implemented from the beginning to end, and if we started at the beginning, the whole world would change by the time we got to the end. That leads us to that last term, incremental, so the plan that we proposed, and I'm excited that CMS in this environment of change had adopted or allowed us to pursue, is an incremental approach to focus on those things that we absolutely need to meet the requirements of 2014. Those things that are nice to have, that we would love to have, would have had, but are not required to meet October 2013, January 2014, choose the date, put those into 2015, and then take the things that are most important in the very short term and start delivering them. Under the enhanced funding, we've already made a stride with a pilot in one of our largest offices for electronic document management which will be one component of the bigger system.

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We need to replace the eligibility rules engine, a separate phase, and in our APD we proposed, I believe, six or seven phases to meet those requirements. I think the real key for myself and other technology side leaders is what is minimally required. What's your long-term plan, and how do you move toward that, knowing we can't do everything today? One of the things that I talk a lot about in the iterative piece is if we have this plan that requires three iterations, but other things distract us, become priorities, and we only do this first iteration, does it make the lives of our families, our staff, or our provider communities better. If so, it's worth doing it, and let's get it out there. That's a transformation that I think is very much tied to how we think about technology, how we think about its implementation in the Medicaid program, and I think in government in a broader sense, and it really continues to be driven by what are the process outcomes that we need to deliver.

CINDY MANN: If I can quickly add to that, I think John is the perfect advertisement for the direction that we think the states need to be going in and that our new regulations and

our procedures are geared towards helping states do that, which is take things in chunks. Do what you do well, exchange and share chunks across states. We do not want to pay for, nor do states need to pay for, something that six other states have already done if that can be lessons learned or stolen from one to the other [laughter]. We've created an IT platform for states and have actually required them to deposit their artifacts on that platform for other states to be able to use it and pick and choose. The modular approach, the incremental approach, the continuing improvement approach is very much sensible because we have had many decades of major projects going on and not always to successful completion.

PHIL GALEWITZ: Phil Galewitz with Kaiser Health News, two questions I'm wondering if Cindy and Tricia could address. CMS has talked about they've done a fair amount of progress in enrolling kids who are qualified but are not enrolled in Medicaid. Has there been much improvement as far as adults who would qualify for Medicaid, but are not enrolled? The second question, I'm wondering if you could talk about, there've been a lot of staffing cutbacks in a lot of state capitols. You may

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have heard, there's a big law suit filed in Connecticut against the Medicaid issue saying these staffing cutbacks have led to making it so it's harder to sign kids up for Medicaid. Have you seen this around the country, and can you talk about it?

CINDY MANN: There hasn't been as much data available in looking at what's going on with adults, but we have seen, generally, that there's been improvements in adults. Following along, I think the chart that Tricia showed is that we have increasingly seen, over the years, states picking up on the kind of proven advances that they've done for children, and say well wait a minute. Families are families. We should apply it to the parents, and then thinking more broadly to the extent that they're covering other populations of adults beyond parents and kids. I think the progress for eligible but unenrolled adults is lagging behind kids, but it is moving in exactly the same direction. As John points to, you develop a system; you develop a process improvement. There is no reason, and there're lots of reasons otherwise. You don't silo it. You think about your process improvement across your populations, and certainly we're looking at it and we think

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that's increasingly how states are looking at it. Certainly, for 2014, a broader approach is required.

Staffing cutbacks are real issues for states. They're facing an extraordinary amount of pressure, and the administrative costs tend to be thin already in the Medicaid program but getting thinner because of budget constraints. It does cause issues. It also stimulates creativity. I think Dayanne has talked about creativity as one of her magic ingredients. Some of the improvements, for example, that Louisiana has done over the years that has gotten their procedural denials on renewals to nearly zero, literally nearly zero and not just for kids, have lessened the workload on their local staff, so at some point it seemed like maybe it takes more work to make sure the case doesn't get closed. In fact, it turned out that the procedures that they adopted, some of which were technology based, but some of them were very hands on in terms of contacting families, in the end turned out to be savers in terms of administrative expenditures. I think it does push a lot of states to be looking for new ways of moving forward.

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TRICIA BROOKS: I think Cindy's right. I was going to mention Louisiana as well because we've seen graphs that show the increasing caseloads and the staff level remaining relatively flat and even taking a dip in the past couple of years. If you look out over a decade, the diminishing administrative resources were cited virtually in every state. We know that they're strained, and so whether it's just staffing or freezing vacant positions as people leave, doing early retirement buyouts, there's no doubt that this has had an impact not only on the manpower that's available, but also on the historic knowledge of how the agency runs and how they do things. I think it's a stressful time for Medicaid eligibility staff, but you see these states stepping up. I think it's important that we continue to record some of the progress of the innovator states so other states can look at that and go, ah, if they can do that, I can do that. When you particularly see states like Utah has a very advanced system. Oklahoma was one of those states that had less than 200-percent in child eligibility, but they have the first online, real-time automated system and that states need to keep borrowing those

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proven practices from one another, but no doubt, it's a tough time for eligibility.

DIANE ROWLAND, SCD.: I'm aware we're out of time, but we're going to take two more questions, one here and one in the back, and ask the panel to keep their answers brief.

DOUG TRAPP: Hi, I'm Doug Trapp with *American Medical News*. There's been a lot of talk from governors and state leaders about the cost of Medicaid and CHIP coverage, about the sustainability of it, a lot of worries on their part. I'm wondering if you could talk about the value, what states in the program are getting for their money, their Medicaid and CHIP dollars. We heard one story earlier, but could you talk about it in a bigger sense?

CINDY MANN: There're multiple ways to measure the value of the investment in health care coverage, and I think most of us choose to have health care coverage because we understand the value in that personal sense to ourselves, our family members, and our children. I think that the idea of coverage is, are we connecting people to good care. Surveys in the Medicaid program, we just finished a survey that showed

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that 93-percent of parents with kids enrolled in Medicaid and CHIP were satisfied with the care that their kids were getting. Almost two-thirds of them were very satisfied. Nine out of ten had no problems finding a doctor. We know we have some issues in some parts of the country and for some specialties, and we need to work on that. If you look at Marilyn who was able to get glasses and see in the classroom better than she was the day before she was enrolled in the Medicaid program, that gives you a beginning glimpse of what can be accomplished.

I think as John said, increasingly what states are focusing on, and certainly we're working with many of them in this area, is let's get past the issue of getting people covered and churning. Let's keep people insured, and then let's focus on making sure they get good quality care and that we're working on improving that care as much as possible so that we can provide better health, better quality, and do so at lower cost.

DIANE ROWLAND, SCD.: Last question at the back?

LAURIE ALBAN HAVENS: Hi, my name is Laurie Alban Havens. I'm with the American Speech-Language-Hearing

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Association, and interestingly, you made the comment about providers and difficulty with access to providers, and you had made the comment, Mr. Supra, in South Carolina about you go to the physicians and say are you ready to absorb those people. That's my question. I appreciate, greatly, the enrollment factor, but then what are you doing for the providers or to help the providers to become available to provide those services?

JOHN SUPRA: I think it starts, in our state, as we look at expanding this access in doing these express lane activities, starting to talk with the communities, so it involves the providers. I think the question earlier about the health systems within the schools, alternatives to traditional providers, how can the community partners that are represented provide some of that. As we look forward to health care in the broadest sense in health outcomes as a healthy community, I think it's the challenge to all of us to rethink what that exactly looks like. It means our providers become a broader group of people, and they provide different pieces of the health care puzzle. I think that it means communities as a

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whole figure out what works in local communities which may be different in different communities, and it becomes our responsibility to look at how do we measure these things to insure that we are getting the value for the dollars being put into the programs. As we've moved forward on the coverage and made good progress, as we move forward in South Carolina, and I think many states are, we're thinking about that family of care as we put these policy changes, these programs in place.

DIANE ROWLAND, SCD.: I think we've clearly seen today that coverage starts with enrollment, but it doesn't stop there. It translates into much more on the ground. I think we've also seen that it takes real leadership, but that as Dayanne said, we can do it and that clearly everyone can take away many messages of how to get there, but it certainly takes people like the panel and researchers we have here to keep us going. I want to thank everyone for coming, and especially our panel for being with us. [Applause].

[END RECORDING]

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