Getting into Gear for 2014: Kaiser Briefing to Release New Data from 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Policies
Kaiser Family Foundation
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DIANE ROWLAND: Good morning, and welcome to the Barbara Jordan Conference Center for this briefing this morning on Getting into Gear for 2014: A Briefing to Release New Data From our 50-State Survey of Medicaid and CHIP Eligibility and Enrollment Practices, and to really talk about what's going on, on the ground with regard to health care coverage for the low income population.

As we begin 2013, we're now less than a year away from the implementation of the major coverage provisions of the Affordable Care Act, including, of course, the Medicaid expansion, as well as the creation of the new exchanges for health care marketplaces.

Following the Supreme Court's ruling, of course, it effectively made many of the issues with regard to the Medicaid expansion up to the states for their choices. Many states are now continuing to weigh the factors about whether to move forward and what this will mean. However, in addition to the concerns that many states have had, we know that many states are moving forward very rapidly. We're very pleased today to have about 20 states indicating that they will expand coverage, while others continue to weigh it, and today with us is one of the states moving forward, the State of Colorado.

2014 will also usher in some very important changes in states with the coverage expansion and without. It will change many of the requirements for how Medicaid enrollment works and how that

experience will be for families, making it easier, not only for families that are newly enrolling, but especially for those who are already covered by the program.

Today, as the year unfolds, we're going to begin to see many innovations at the state level. We're going to be able to see how different approaches are being taken to try and improve coverage. We wanted to share one example with you today from the great State of California and Alameda County of how one can really get out and try and do outreach and enrollment and get people covered. I guess I can do this.

Here's an innovative approach to trying to say let's get your family covered. If you can provide them with clothing and other things, you ought to also provide them with health insurance coverage. Today, we're going to be examining, in our key reports, some of the major issues that other states are struggling with.

We're releasing two key reports at this meeting. The first is our 12th Annual 50 States Survey of Medicaid and CHIP Eligibility Enrollment and Cost Sharing Policies, which illustrates the significant progress that states are continuing to make as they prepare for 2014 and provides an important baseline showing areas where states will need to continue to make changes. We're going to have that report presented by Samantha Artiga, our Associate Director of the Kaiser Commission on Medicaid and the Uninsured, and Tricia Brooks, a Senior Fellow at the Georgetown University Health Policy

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Institute, Center for Children and Families, and as you see, the co-authors of the report are presented there.

Following that, we always try to also provide the perspective of what it means for people, for these expansions, how they work on the ground for the families that are affected. We're going to present a second companion report, *The Faces of the Medicaid Expansion*, which will be presented by Jessica Stephens, a Policy Analyst with the Kaiser Commission. This report really shows the personal experiences of low income adults who have gained Medicaid coverage in the states that have already expanded coverage.

We're going to ask these report authors to come up and briefly present the materials from their report and then turn to a great panel that will provide us perspectives, not only on the reports, but also on what's going on on the ground. Cindy Mann, known to all of us, Deputy Administrator of CMS and Director of the Center for Medicaid and CHIP Services; Nico Gomez, the Deputy Chief Executive Officer of the Oklahoma Health Care Authority; and Lorez Meinhold, the Deputy Executive Director and Director of Community Partnerships for the State of Colorado's Department of Health Care Policy and Financing. I think this will be a great discussion to really set forward what the challenges are going forward toward 2014, but also what much of the progress on the ground is to date, so that we really know how much more we need to accomplish, but how much

we've gained so far. With that, Samantha, please start our presentations.

SAMANTHA ARTIGA: Thanks, Diane, and thank you all for being here with us today. We're really excited to share these new survey results with you. Before I start, I wanted to recognize the many people that are involved with pulling this survey together every year, because it truly is a team effort. I first want to recognize my co-authors, including the lead author, Martha Heberlein, as well as Tricia Brooks and Joan Alker from Georgetown University Center for Children and Families and my colleague, Jessica Stephens, from the Kaiser Commission.

Secondly, I really wanted to take a moment to extend our appreciation to the many state officials who participate in this survey and make it possible. As you'll see from the findings that are presented today, state officials are probably as busy as they ever have been this year, and so we really appreciate them so generously sharing their time with us to complete the survey.

I wanted to start with a brief overview of what the survey is. As Diane mentioned, this is our 12th Annual Survey, which covers policies in all 50 states and DC. It's conducted through telephone interviews with Medicaid and CHIP administrators and covers Medicaid and CHIP eligibility, enrollment, renewal, and cost sharing policies for children, pregnant women, parents, and other adults.

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Each year, we slightly adapt the survey instrument to reflect key activities that are going on at the state level for that year. This year's survey continued to track adoption of coverage and enrollment simplification options that were provided by the reauthorization of CHIP in 2009, known as CHIPRA, as well as early steps related to ACA implementation. Particularly, this year related to states continued growth in the use of technology as part of their enrollment and renewal processes.

The data that you will be seeing today represent changes that took place during 2012, as well as policies that are in effect as of January 1, 2013. As we enter into this final year before the major coverage provisions of the ACA go into effect, it really provides an important baseline of where states are today and the changes they will need to continue to make as they final their preparations for 2014.

As we look at the survey findings, I think it's important to keep in mind the context of a number of key factors that happened over the past year that influenced state policies. Just getting started, the economic picture was improving for states which experienced positive revenue growth and is slowing in their Medicaid enrollment and spending growth over the year. Then there also were a number of actions related to ACA implementation, final regulations to implement the ACA's streamlined eligibility and enrollment system for Medicaid and the other insurance affordability programs, including

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exchanges, were released. The Supreme Court ruling upheld the ACA, but as Diane mentioned, it effectively made implementation of the Medicaid expansion a state choice by limiting the ability of HHS to enforce it. The election results affirmed continued implementation of the ACA, and the ACA requirement for states to at least maintain eligibility and enrollment policies remained in place.

In addition to these factors, there are a number of coverage and enrollment simplification options that were made available by CHIPRA as well as the ACA that were options out there for states to take up over the year. What you'll see is that as states continue to upgrade and build the new enrollment systems in preparation for 2014, there became a growing set of IT-related knowledge and products that are now available to states and which HHS has been taking steps to try and facilitate the sharing among states as they move forward. This really builds on the significant Federal funding that had previously been made available to support state work with upgrading and building new IT systems.

As I mentioned, one of the key actions that happened during 2012, which has particular relevance for these survey findings, was the release of the final regulations related to Medicaid eligibility and enrollment under the ACA, which will expand Medicaid eligibility and really transform the Medicaid enrollment experience. Specifically, as Diane mentioned, the ACA expands Medicaid to a minimum floor of 138-percent of the Federal poverty level. However,

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as was noted, the Supreme Court ruling effectively made implementation of that expansion a state choice. Independent of state decisions to expand Medicaid, however, there also are new simplified enrollment and renewal requirements that are really designed to provide a streamlined enrollment experience for families for both Medicaid as well as other insurance affordability programs. Some of these include a single streamlined application that will be available for all of the programs and that individuals will have the option to submit by phone, by mail, in person, or online. There are also some streamlining of enrollment and renewal requirements, and notably, a real shift to relying on electronic data to verify information, instead of paper, with a goal of having as many real-time determinations as possible as part of the new system.

Lastly, I want to point out that the requirements are also designed to create a no-wrong door coordinated enrollment system for Medicaid and other insurance affordability programs, so that regardless of which program someone applies for or the mode through which they apply, they land up in the coverage for which they are eligible.

Turning to our survey findings, what you see here is that during the past year, a little over half of states went beyond holding steady to make improvements in their Medicaid and CHIP programs through targeted coverage expansions as well as continued improvements in enrollment and renewal processes that build on

progress that we've seen over the last few years. On balance, states made more positive changes than restrictions, and this reflects both the continued improvement in the state economies as well as the ACA requirement that states maintain coverage. These improvements largely utilized the new coverage options that were made available by CHIPRA and the ACA, as well as the harnessing of technology to gain administrative efficiencies and reduce paperwork as states focused on streamlining their enrollment processes.

As you'll hear from Tricia in more detail, a number of states went beyond making incremental improvements and really shifted to focus on making wide ranging process and system improvements in preparation for 2014.

In the next couple of slides, I'm going to focus in a little bit more on the findings related to eligibility, and then I'm going to turn it over to Tricia, who's going to pick up and talk more about enrollment processes, as well as use of technology among the states.

Here, starting with children's eligibility, you'll see that children's coverage remains stable and strong during 2012, with nearly all states now covering children up to at least 200-percent of the Federal poverty level in Medicaid and CHIP as of January 1 this year. Moreover, during the last year, nine states made continued improvements in coverage for children, largely through take up of options provided by the ACA and CHIPRA to cover dependents of state

employees and well as lawfully residing immigrant children without a 5-year wait.

However, adult eligibility continues to fall far short of that for children, and a few states scaled back coverage for parents and other adults during 2012. Here, you see that the parent eligibility levels for Medicaid remain very low, with the median at just 61-percent of the Federal poverty level compared to 235-percent for children. Moreover, most states don't cover other adults without dependent children, oftentimes referred to as childless adults, regardless of how low their income is.

During 2012, one state, Colorado, who is here with us today, expanded Medicaid to adults, and Utah also made a small expansion in one of its waiver coverage programs for adults. In contrast, there were three states, Hawaii, Illinois, and Minnesota, that reduced eligibility for adults under a limited exemption to the ACA requirement to maintain coverage that applies to adults over 133-percent of the Federal poverty level.

Given the current limited eligibility levels for adults, it's clear that the ACA expansion to 138-percent of the federal poverty level would significantly increase eligibility for parents in many states. As of January 1, 33 states currently limit parent eligibility to less than the Federal poverty level, which I will remind you is about $19,000 for a family of three. Sixteen of those

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states limit parent eligibility to less than half the Federal poverty level.

Potential coverage gains under the Medicaid expansion are even larger for other adults, childless adults, with only 9 states providing full Medicaid benefits to these adults today. Taken together, when we look at these eligibility levels for parents and other adults, they really point to be importance of the Medicaid expansion for improving their access to coverage. If a state does not implement the Medicaid expansion, many poor, uninsured adults in that state will continue to lack access to affordable coverage and likely remain uninsured. Here, we really see the opportunity of the Medicaid expansion to increase their access to coverage in many states. With, that I'm going to turn it over to Tricia to pick up on the enrollment process findings.

TRICIA BROOKS: Thanks, Samantha. Hello, everyone, and I want to thank the Kaiser Commission on Medicaid and the Uninsured for allowing the Georgetown Center for Children and Families to continue to partner on this really wonderful piece of work. I know we're used this survey and the report as a resource for many, many years, taking over for Donna Cohen-Ross, who is helping things more forward at CMS, but we're really pleased to be part of the project.

I also want to echo Samantha's appreciation to the state officials who spend a lot of time with us, not only looking over the data we send them from last year to make sure we've got a good

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baseline, but talking with us on the phone, verifying the data that we're going to publish each year. This year, more than ever, we know that that time was extremely limited, and we continue to appreciate it because we would not be able to be here without that.

Let me see if I can get this right, as Samantha pointed out from the first slide, 23 states took favorable actions to simplify their enrollment and renewal procedures. As you can see, there were a variety of actions that were taken by the states, but almost all of them basically used technology to streamline coverage for families. About half of those actions really dealt with online applications and enhanced online tools, such as accounts being able to upload documents, some of those kinds of things. Then nine states actually diversified their renewal methods; again, most of those online but also some over the phone. We're going to drill down into some of these particular options as we get further in the slides.

The ACA's no-wrong door approach to simplified streamlined eligibility enrollment is built on the successful strategies that states have pioneered, most often in maximizing children's health coverage. However, the goal of modernizing the application and renewal experience for families is absolutely dependent on deploying high performing eligibility and enrollment systems. Thanks to the unprecedented, but time-limited federal financial support to upgrade or replace aging Medicaid systems, nearly all states are moving forward on significant IT development projects.

Forty-seven states indicate that they have submitted or received approval for the 90-percent Federal matching funds for their Medicaid IT systems, and several more signaled that they plan to submit in the near future.

Design and development work is well under way in 42 states, and again, several more were in the process of concluding their RFP processes to select a vendor as 2012 came to an end.

Web-based enrollment and renewal are really at that heart of that streamlined system that's envisioned by the ACA. The number of states that now are offering electronic applications with electronic signatures has been steadily growing. A total of 37 states have electronic applications, and all but one of them accept electronic signatures.

Thirty-six states also offer additional tools through online accounts for families to report changes, to check the status of their benefits, and perform other functions.

More rapid progress has been seen very recently in the number of states offering online renewals. Just three years ago, only six states provided children with an option to renew online. Since then, more than 20 states have added this simplification for families, bringing the total to 28.

As Samantha indicated, we do adapt the survey every year. We've certainly started to drill down into some of the more advanced uses of technology. One of the new questions this year was whether a

state offers the functionality for a consumer or an application assister to upload a scanned document. This is a really useful feature, because even with the most current and reliable data sources, people will always have changes in circumstances that impact their eligibility and cannot be immediately verified. In those cases, states may accept self-attestation, but they may also choose to require documentation. Offering a way to submit documents electronically is very advantageous. I was really pleased and actually a little surprised to see that 15 states already have this capability.

Another advanced use of technology and the web is to allow consumers to elect to receive their notices electronically. Four states are blazing the trail and reaping the benefits of what really is a more timely and cost effective means of communicating with applicants and enrollees. These states have some practical experience that will be helpful for all states that will be required to offer electronic notices going forward according to the latest proposed rule, assuming that provision becomes final.

As we've mentioned, states have to adopt a no-wrong door approach, which is really about whether you come through the Medicaid or the CHIP agency or through the exchange and be able to have your eligibility determined for all programs. Additionally, states must diversify the methods through which people can apply.

Today, all states offer the ability for people to apply online, excuse me, through the mail, or in person, but beginning in 2014, in addition to that, people must be able to apply, not only apply, but renew, as well as report changes online, in person, over the phone, or by mail, or fax. Offering these new ways to renew was the second most prevalent change that we saw in 2012. States are well on their way to providing all four methods of submission, with nearly a third of the states already meeting this objective.

Despite our hopes for electronic data verification, it's probably not going to eliminate paper documentation entirely. There are a lot of ways that states can promote a paperless environment that will either enhance or expedite the eligibility verification process.

I noted before that uploading a scanned or electronic document is useful. It's equally important to have a place to electronically store that document and link it to a specific client case record. That doesn't just eliminate paper, but it also provides access to information that was previously contained in a paper file in a single location. If a family moves from one county to the next, the new county can take a look at that record and be able to access information that the family has already provided. To that extent, document imaging systems are really important, and 30 states have implemented them in either Medicaid or CHIP and 22 states have then in both programs.

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The administrative renewal process is another way that enables states to access an enrollee's ongoing eligibility before requiring that they fill out a renewal application. They actually occur in a variety of ways in the states, but each is intended to eliminate the need for families to return paperwork if their circumstances have not changed. Today, nearly half of the states have some method of processing renewals administratively, putting them closer to the ACA's vision of automated renewals, which is one of my personal favorites within the Health Reform Act.

Even though there was the possibility that express lane eligibility would sunset in September of 2013, it has been extended for another year. Five new states implemented this CHIPRA option, bringing the total number of states to 13 that are using eligibility findings from other means-tested programs to determine Medicaid or CHIP eligibility.

This year's survey also identified 11 states that have state data hubs or some alternative type of data brokering system that can facilitate access to multiple sources of verification data at one time. Beginning in 2014, we know the Federal data services hub will provide access to electronic data that states will need, such as MAGI based income from the IRS, citizenship, and immigration status, as well as, hopefully, other eligibility criteria. States will still need to access more current sources of income and other eligibility criteria that is much more efficient if there's some

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mechanism like a hub or a data brokering system to do so. Eleven states are already there.

Last, but certainly not least, outreach and enrollment assistance is another area we drill down into a little bit more. We know that the states that have achieved success covering children or implementing broader coverage expansions, credit outreach, and consumer assistance as key strategies contributing to their coverage gains. As expanded insurance options become available, the importance of outreach and assistance to help eligible families and individuals enroll will only get larger. Even with consumer-friendly online applications, some consumers will need or want direct one-on-one support. The ACA recognizes this by boosting requirements for consumer assistance that is accessible for all individuals, including people with disabilities or limited English proficiency. Currently, nearly all of the states offer in-person assistance at eligibility offices or offer a toll-free hotline to help consumers enroll in Medicaid or CHIP. A significant number also use out-stationed eligibility workers or fund community based application assisters to provide help in places other than government offices. States will need to build on these existing sources of consumer assistance to ensure that the millions of families that are expected to connect to coverage will get the help that they need in 2014.

In closing out, we just want to talk about the implications of the survey findings going forward. We know that Medicaid and CHIP

continue to be the bedrock of coverage for pregnant women and children, thanks to the Affordable Care Act's requirement that states maintain coverage. Parents and childless adults have not fared as well. In light of the Supreme Court ruling effectively making it a state option to expand Medicaid, what is really clear is that considerable gaps in coverage will persist for the lowest income adults if states fail to take advantage of the general Federal funding to expand Medicaid for parents and adults.

States continue to build on the significant gains they have already made to offer simplified, modernized enrollment experience that both increases access to coverage and improves government efficiency. Nearly every state is pressing forward with major information technology and process improvements to transform the Medicaid enrollment experience in to a real-time, data driven process that will be required in 2014.

There is a growing repository of products, resources and knowledge gained from states leading the way and harnessing technology to achieve the vision of web-based paperless system that will enhance the learning curve or accelerate the learning curve of those states that have gotten off to a slower start. Sharing these resources and providing technical assistance are critical for states, because open enrollment is 250 days away and January 1st is 342 days away, but who’s counting?

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DIANE ROWLAND: Jessica will share with you some of the findings from the faces of the Medicaid expansion.

JESSICA STEPHENS: Thank you, good morning, and as Diane mentioned, I will be presenting the second report that we're releasing today. You should all have a copy in your packets. It's the one with the faces on the cover, and it's The Faces of the Medicaid Expansion: How Obtaining Medicaid Coverage Impacts Low-Income Adults.

This is a report that Samantha Artiga and I worked on this past fall, alongside Michael Perry and Naomi Mulligan of Lake Research Partners. My intention this morning is to provide a brief overview of the study and then present some key findings, but hope you will look at the report in a little bit more depth.

The objective of the study was to identify the impact that obtaining Medicaid coverage has on low-income adults' health, their finances and other areas of their lives. To do that, we used a structured guide to conduct a series of focus groups with previously uninsured adults who recently gained Medicaid coverage. We went to states that have already expanded Medicaid to low-income adults in advance of 2014, specifically California, Connecticut, Minnesota and DC. Although those states have different eligibility levels for both parents and childless adults, we included in the focus groups only those previously uninsured adults with incomes under 138-percent of the Federal poverty level, which is the minimum Medicaid eligibility

threshold in 2014. We also had a diverse range of participants, so we had a mix of gender, race/ethnicity, income, education, employment and we included both healthy individuals and those with serious and chronic illnesses, and physical and mental health needs. Finally, we conducted some in-depth follow-up interviews with selected participants that informed the individual profiles that you can see at the back of the report.

One of the key goals was to first get a good sense of adults' experiences being uninsured just prior to gaining Medicaid coverage, and what we learned was that being uninsured caused significant fear and anxiety. What you see here is a word cloud, which is a visual representation of the words that participants used to describe what is felt like to be uninsured. Clearly, participants felt scared while they were uninsured. They said that it was a scary process, because they didn't know where they would be able to access care. While they were insured, they didn't know how they would be able to pay for that care. They also felt uneasy. They found it to be a very stressful and nerve-wracking experience.

In addition, while uninsured, participants could not afford needed care, and this had negative consequences on their health and their finances. For one, low-income adults could not afford to pay for out-of-pocket care for ongoing treatment or medications for conditions like diabetes or depression. Like Ruth, one of the participants we met in Connecticut, many skipped medications to try

and make them last or some went without medications or treatment altogether.

Secondly, participants also told us that many had to make difficult choices between seeking treatment and bearing the high out-of-pocket cost for that treatment on one hand, and then not seeking treatment, but having to deal with conditions on their own and possibly having those conditions worsen. For example, in Minnesota, we spoke to Susan, who suffered a severe head injury when she was uninsured. One of the things that happened was she decided not to seek care, because she said she couldn't afford it, but her condition developed into a much more serious staph infection that ultimately required a long hospitalization. John, who we also met, said that he broke his hand on the job, and he did decide to seek care from the emergency room but he couldn't afford follow up care for his condition, and he still had to work for two months with a broken hand. These two examples are very representative of the types of stories we heard from many of the participants we spoke to across states. Many put off care, were heavily reliant on the emergency room, and were still suffering with the high cost and high debt from when they were uninsured, even though they now had Medicaid coverage.

One other thing that we noticed was that many said that having untreated conditions had negative consequences on their lives more broadly. For example, Stephanie told us that she lived with chronic pain that limited her ability to work when she was uninsured.

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Many other participants had physical, mental, sometimes emotional health needs that often affected their personal relationships, their jobs, and their ability to just participate in everyday activities.

In contrast, participants said that obtaining Medicaid coverage bought big sense of relief. This is another word cloud that describes the words that participants use to describe what it felt like to obtain Medicaid coverage. You can see the contrast between this one and the last one that I showed. Participants told us very frequently that they no longer had to worry about being able to afford care or being able to access services, and it bought them peace of mind. They felt very secure being able to have health coverage, but also very thankful, grateful for the coverage that they had so that they could access preventive services and other care that had gone unmet while they were uninsured.

More concretely, obtaining Medicaid enabled participants to access care for unmet needs and preventive care, which improved their health and their lives more broadly. For example, Matthew in DC told us that while he was uninsured, he put off care and he ultimately had to go to the ER a few times because his conditions worsened. Now he says that he is able to go to the doctor. He said he's able to get his medications and get his needs met early so that he can address his concerns before they get worse. He also said obtaining Medicaid coverage allowed him to access preventive care, and this was something that came across very clearly across the different groups.

People expressed relief in being able to access preventive services, and for many participants, this was one of the first things they did when they enrolled in Medicaid. They went and they got services such as physicals. In that process, a few learned that they had conditions such as diabetes or depression, for which they are now receiving care.

Another key finding was that many participants developed strong relationships with primary care physicians to coordinate their care, sometimes through team-based approaches. For example, Nicole, who we spoke with, said that she suffered with high blood pressure and used medications to manage her high blood pressure prior to gaining coverage. Now that she is insured, her blood pressure is now under control, and she got it under control with the help of her primary care physician who helped her manage her diet, helped her exercise more, and she says she feels knowledgeable about what hypertension is and how to prevent it.

This is something else that was echoed across groups. People said that they now feel that they're able to lead healthier lives because they have better diets or better exercise habits and, in one case, one individual said that his primary care physician helped him to stop smoking.

One thing that came across clearly was that obtaining Medicaid coverage did make a difference in many of the participants' lives more broadly, and getting care for conditions that had

previously gone untreated meant that they could focus on other aspects of their lives, for example, looking for better employment or caring for their family members. For example, Salvador, who you see at the bottom of this slide, said that, to some extent, obtaining Medicaid coverage allowed him to be a better father, because prior to gaining coverage, he said that he suffered with severe asthma. He had knee pain that prevented him from being physically active with his daughter. He says now that he has these conditions under control. He's worked with his physician to get his asthma under control and figure out exercises for his knees, and he says he can be more active. He can play soccer with his doctor. Not with his doctor [laughter]. He could play soccer with his doctor, but he could play soccer with his daughter, and he said that that provides some comfort.

Overall, these findings suggest that expanding Medicaid would have significant positive impacts on individuals' personal lives. For one, they might enable individuals to obtain needed care and utilize physicians, rather than delaying care and relying on the emergency room. This has potential trickle down positive effects as well, for example, being able to have earlier diagnosis and treatment of conditions and also provide better care management, could ultimately lead to less serious and less costly conditions.

Secondly, Medicaid provides financial protection from the cost of care and alleviates a significant source of stress and worry for many of these adults.

Third, Medicaid has the potential to help individuals get their health under control so that they can focus on other priorities and goals, including employment. This again something that came across very clearly. People said that they had conditions, for example, that kept them at home, that limited their mobility, and now that they're able to be active, they can focus on these other priorities in life.

I would encourage you to read the profiles at the back, especially, in a little bit more detail, because they provide some concrete examples of some of these aspects that I mentioned. They highlight that, in addition to cost, and budget, and all of these other important considerations, the broad array of potential personal consequences of obtaining Medicaid coverage is another factor to be considered as states weigh going forward with the Medicaid expansion. I'll turn it back to Diane.

DIANE ROWLAND: Thank you, Jessica. I think this clearly shows that not only do the simplification of eligibility processes connect people to care, but that that care really matters. Our panel is going to really highlight, I think, some of the ways in which improving the system and getting people covered and connected to care is so important. We're going to start with Cindy Mann.

CINDY MANN: Great. Thank you, Diane. First of all, much thanks to the Kaiser Commission on Medicaid and the Uninsured and to the Georgetown University Center for Children and Families for these two really enormously valuable reports.

I'm going to focus, as Diane said, a bit on the survey and some of the simplification measures that have been taken over the years by states, what we've learned from it, and what we can expect as we move into 2014.

Over the last dozen years, through its 50-States Survey, the Kaiser Commission has been tracking the evolution of Medicaid and CHIP eligibility and enrollment simplification. What emerges from that long history of reports is that there is a rich tradition in this nation to learn about what works and to increasingly adopt the procedures that have been shown to work to get eligible people enrolled and also to assure that they can stay enrolled for as long as they're eligible. We've also seen that this, as Diane alluded to, that this simplification comes with enormously demonstrably positive results.

We've seen over time that as enrollment barriers go away, as renewal barriers are eliminated, enrollment of eligible people, participation rates of eligible people increases and the uninsured rate for individuals' declines. As a result of a continuing cycle really of better policy and valuable research that allows us to really share the lessons over the years, we've made enormous

progress. Soon, in less than a year, as Tricia has pointed out with precision, those simplified features will be the way things are done in every state for most of Medicaid, as well as for the children's health insurance program, as well as for the calculation of the premium tax credit that'll be available through the new exchanges. Let's a little bit at how far we've come.

We did a little survey of our own back through these dozen Kaiser surveys, and it's a little bit like going back to the future. Remember the movie where Michael J. Fox went back in time and he amazed people with the tales of how someday radios would be small enough to fit in your pockets and you could drink soda without calories? That was his message about what the future holds. The reports are, many respects, looking at the future. It's remarkable how much change has happened and also the extent to which things that we now take for granted were heralded, at the time, as major advances.

Let me give you a couple examples. In 2000, the very first Kaiser survey documented states efforts to stop counting assets when they looked at eligibility in the Medicaid and CHIP programs. That was a new simplification that states were taking. It was principally focused on children. It was an option for states, and the Kaiser study looked particularly at and highlighted my colleagues here in Oklahoma and showed that they had dropped the asset test. What that meant is that 20 different questions on the application, details

about this asset, that assets, never a simple question, could be eliminated from the process. The application, largely for that reason, although there were other changes as well, shrunk from 12 pages to two pages. Of course, the application process got more simple and enrollment increased. Oklahoma noted in the report a year later that it had saved $1.2 million in annual state administrative cost as a result of the simplification.

Today, we have 47 states that have eliminated the asset test for children and 24 states have done so for parents. Three years after that first Kaiser Report, the 2003 report, showcased Michigan and talked about how Michigan had begun a new process that Tricia talked about in terms of moving away from paper documentation and looking at trusted data sources in order to verify eligibility. As a result, Michigan documented that the percentage of applications that were denied simply because they were incomplete, not because the person was ineligible, but simply because the paperwork was difficult for everybody to get through, that percentage denied for procedural reasons declined from 75-percent to 20-percent. Of course, enrollment grew without jeopardizing program integrity.

Many states have moved in that direction. In 2006 and 2007, the Kaiser Report also looked at the impacts of paper documentation. Those reports both looked at the new citizenship documentation requirement that had been adopted by Congress in the Deficit Reduction Action of 2005. Those reports looked at the way

paper documentation had caused eligible citizens to lose eligibility or not get into coverage as a result of procedural bearers. Congress changed the law in 2009 with CHIPRA and allowed states to use data matching with the Social Security Administration to verify citizenship. California was one of the first states that picked up that option, documented that it saved more than $26.5 million a year as a result of the simplifications, moving from paper world to a data-based world, and today we have 42 states that have implemented that option for both Medicaid and the CHIP programs.

Over the years, Kaiser's survey has shown how the application process itself, not just the specific elements, but the process itself and has evolved. Tricia spent some time talking about this this morning looking at her survey. It used to be, not so very long ago, that applications for Medicaid pretty much had to be done in an office, in person, with an interview. Then, the big change that happened a few years back is that we moved, we the country, generally moved from those in-person interviews to a mail-in application, and as the survey shows, now we are moving to an online environment. Still some people will want to come in person, still some people will want to mail their application, and some people will be doing applications by phone. Increasingly, individuals are applying online, and today, as the survey showed, we have many states with online applications in the Medicaid and the CHIP program. As the survey, shows they're really incorporating some additional

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features that make them even more valuable for consumers, as well as for states.

Based on all of these experiences and really catapulted by the progress, as we prepare for 2014, we are now poised, our collective we, to take that next leap forward, where these best practices are no longer heralded as the new advances, but are understood to simply be yes, of course, that's the way we would do things. No more strange and no more unexpected than iPods or Coke Zero.

In 2014, there will be no asset test for most of the Medicaid program, most of the people applying in the Medicaid program, as well as for CHIP and for people applying for the premium tax credit on the exchange. In 2014, in an age of quickly advancing technology, people in every state will be able to apply for Medicaid and CHIP and for the premium tax credit online through one coordinated corss-program application.

In light of ample databases and modernized systems, in 2014, the application process will no longer begin with paper to verify eligibility. The first line of verification will be through databases, and paper will be asked for only when necessary.

State systems throughout the country are now being significantly revamped to accommodate these and other changes to assure that this seamless and coordinated system of coverage is in place. As noted, to help support this effort, we have changed our

rules and provided 90-percent Federal match for systems modernization through the end of 2015, 75-percent match thereafter for maintenance of those systems.

We're also working very closely with states to be able to share and facilitate their ability to share business processes, rules, artifacts from the systems development, so that we are not reinventing that system modernization state-by-state-by-state. Today, 49 states plus the District of Columbia either has an approval to use these funds, or a pending request to use these funds, or a planning grant to move forward.

What we see, and we've seen it throughout the years, is Medicaid is once again reinventing itself. It's a very exciting time. It's a time to modernize and to take that leap forward. I want to stress that I don't think the learning will stop. I think we haven't still tapped out our knowledge and our way of thinking about how to do this all better.

Tricia mentioned one of the new options that was available through the 2009 CHIPRS legislation that was just extended for another year is express lane eligibility. We have 13 states that how use express lane options. It's a way to take information from other programs and to use that information without recomputing and regathering information to make a determination of eligibility in Medicaid and CHIP for children.

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Last year, we had great success by South Carolina. They presented at this same meeting last year about how they were using express lane eligibility for renewals. They found it to be a very successful, very efficient way of operating, and they have now augmented that express lane eligibility so that it's for new enrollments as well as renewals. About 63,000 children have been covered as a result of that effort. We'll have things like express lane and other initiatives. We're working with many states now to think about how to use express lanes in 2014 and how to potentially expand its use so that it also could help states enroll parents and other adults.

For those of us, I count myself among them, who are not technology or gadget geeks, the evolution from the kinds of changes that we've seen, the evolution from that clunky radio to the iPod is not valued, because there's some slick new machine. It's valued because now, no matter where you are, you don't have to carry around your clunky radio. You can hear the weather, you can hear the news, you can hear traffic updates, and you can hear the music, and really it's mostly about the music, right?

Too, when we look at this report and we look at these checkmarks on the tables, the many tables that Kaiser and Georgetown have prepared for us, it is not really about those tables that we're concerned. It's not really about the great new systems that are being built. It's about the music. As Diane alluded to, the music

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for all of us, as we move forward, is to see that people are getting coverage, that eligible people can get covered and that they can stay covered for as long as they are eligibility. That, of course, is the goal. There's many ways to get there, and that's why it's so important.

What we've seen over time is that participation rates as a result of the simplifications that we have, the strongest evidence with respect to children, because that's where the most energy has been paid over the last 10 years or so, participation rates of children in Medicaid and CHIP has steadily increased. At the same time, even though there's been a decline in private-based insurance, we've seen uninsured levels for children consistently decline. They've dropped from 8.9-percent in 2008 to 6.6-percent in the first six months of 2012. That's the music that we're all seeking to achieve.

Medicaid is moving forward. It's moving forward on enrollment. It's moving forward, of course, on eligibility and systems modernization. It's also moving forward to be a strong partner with other public and private payers in improving care and the health of the nation. There could be no more, I think, compelling story about why the Medicaid expansions are so important than the faces of Medicaid, the report that was presented here today.

I want to stress that the changes we're talking about, the simplification changes we're talking about, will be in place in all

states, regardless of whether a state expands or doesn't expand its coverage to low-income adults. If a state does take up the expansion, then that new modernized enrollment system will be there to make sure that they get the coverage for which they're eligible.

Thank you to my colleagues at Kaiser, and thank you to Georgetown, and thank you very much to my state colleagues, who always lead the way and who continue to do so.

DIANE ROWLAND: Thank you, Cindy, and now we're going to turn to Nico Gomez to share with us how the Oklahoma eligibility system is working and the innovations there.

NICO GOMEZ: Great. Good morning and thank you Diane. On behalf of the 500 employees at the Oklahoma Health Care Authority managing the state Medicaid program we call SoonerCare for 1 million Oklahomans, I want to express our thanks to the Kaiser Family Foundation, the Commission on Medicaid and Uninsured for asking us to be a part of this day. It's an honor to be with you all.

Imagine for a moment you're a single parent taking care of three kids and you recently moved to Oklahoma City, and you've taken a job at local dry cleaner. You know your kids are qualified for Medicaid, and you actually went to the local human services office, only to find out you didn't have all of the paperwork you needed to get your coverage. You haven't had time to get back to the office, because you started your job and you work 7 in the morning until 6 at

night, Monday through Friday. There is no way for you to be able to get to the state office during the traditional 8-5 office hours.

Imagine you have a child that has suffered a bicycle crash and had to go to a local hospital ER to get some stitches for a very bad cut. You know you didn't have insurance for your child, but what you didn't know is that your child is actually qualified for SoonerCare, but not knowing it at the time.

Imagine you're a state employee, and you're sitting in a rural human services office in rural Oklahoma, and someone had just came in and taken ten SoonerCare applications and put them on your desk and says we need you to make sure these are processed within the next 20 days.

The news I have to share with you is that this is all history for us in Oklahoma. These were all real life scenarios, and the key word is "were". The good news that I share with you is that in Oklahoma this is all now history. We're proud of that fact. With the support of our Federal partners at CMS, Oklahoma is aggressively using technology to transform old bureaucratic processes into modern Medicaid enrollment systems. Through that, as a result, we've proudly become a recognized leader in real-time online enrollment.

The message I'd like you to take away from today from a state perspective is that it can be done. It can be web-based. It can be paperless. It can be real-time, even though for many states it does seem daunting at times. We've plowed some ground and we hope

can be a technical support to other states going down this road. Not only can it be done and obviously it's required to be done, it really is the right thing to do to meet the needs of our citizens, including those who utilize the services and those who pay for it. The good news is that many states, as you've seen, are already on this journey.

We started this journey in 2007 with a Medicaid transformation grant of Federal funds, about $5 million. It took us about two and a half years of development and testing, and we went live in September of 2010. This effort has resulted in increased efficiency by reducing the workload of case workers processing applications. It has also resulted in consistent and uniform application of eligibility rules.

We have 77 counties in Oklahoma, and the reality is people in those counties may interpret rules differently. We are humans. We remedied this through the development of a rules engine that applies an unbiased algorithm to the application, so that information is applied the same regardless of wherever you entered the system. It goes with you throughout, even in case you move.

It has resulted in a process that is real time, takes minutes to enroll. It no longer takes 20 days to know if you're accepted, denied, or need to provide more information. It has removed enrollment barriers. It is available 24 hours a day, seven days a week. It is no longer tied to the four walls of the state

agency, and the stigma and other limitations that come with that, of having to go down and get state assistance.

As mentioned before, we do leverage electronic verification by communicating with other databases. Why not use the information that's there to make this more efficient? We communicate with the Oklahoma Employment Security Commission on Employment Information, Oklahoma Tax Commission on Income, State Department on Health for Vital Statistics, the Social Security Administration, as well as the SAVE program for citizenship.

It's this technology that has allowed us to strengthen our outreach in our community with community partners and our health care providers. We have many community partners who now have application assistance available to help people navigate through the system. We have health care providers who have kiosks in their offices to help people enroll at the physicians' office, at the hospitals, throughout FQHCs, Federally Qualified Health Centers, that has really made it easier to get coverage, as well as renew coverage, really helps us connect people to medical homes. It's those opportunities and relationships that, for better continuity of care, that better support healthy outcome for our population. All that being said, we're very proud of that. There are challenges still as we continue to work through the technology, and we're learning lessons even now. We will continue to see opportunities to improve our online system as we continue to work with other states as well, going forward.

Let me leave you with a couple of numbers. Nearly 80-percent of our managed care population can access SoonerCare through online enrollment, and that includes children, and pregnant women, and parents. As of November, 54-percent of these applications were completed online via home or public internet site. Another 41-percent were completed online with an agency partner, so they went to and found an agency partner and got some assistance enrolling online. That's 95-percent of applications coming in with that population online. The remaining 5-percent were paper applications, were then converted to electronic.

The last Federal fiscal year, we processed more than 440,000 online applications. Seventy percent of those were approved, so you can see the system is intuitive in the majority of those being approved. I expect, as we go forward, that number would be more refined.

There's an average of four people included in each application, so we know each application is touching the lives of four Oklahomans. Then this is something that we knew and was really reassuring is more than 25-percent of our online applications are submitted in the evenings and on weekends. We have to be able to reach our families at times when they cannot get to the human services office.

Here's some of my favorite numbers, especially when we go down to our state legislature. We had an independent evaluation of

our performance done, and based on the development price tag of $5 million, again, all funded through the Medicaid transformation grant, we have a state annual operational cost of $2.8 million. That includes our contractors, our call centers, mail services, IT expenses. Including the offset of just being able to streamline and reduce our staff time, to be able to process applications, the projected five-year return on investment from 2011 to 2015 is projected to be over $22 million in state dollars, and that's a significant budgetary impact for us.

In the future, it's our desire to expand online options for individuals with disabilities and our seniors. Those are a little bit tougher from an access standpoint and also the amount of information that's required. We are going to move in that direction.

We are looking at interfacing with other programs, such as the WIC program--Women, Infants, and Children--to streamline enrollment as well. You can probably tell that we're very proud of what we've been able to accomplish with this investment in technology. I always have to try to keep my peacock feathers contained a bit. It's really hard to stay humble after we were featured in an article by Allison Weiss in this month's *Health Affairs* and I'll give a plug or encourage you to look that up.

I think my favorite sentence is, and I'm going to put this on my wall, my favorite sentence is, "Oklahoma is a shining example of how to do things right. And while we're not resting on that, it

really does give us the motivation to keep pressing forward, to measure our success against ourselves to do what is right for the SoonerCare members who need our program for their health care." That's the music we're listening to.

If you want to see our website, you can see it at mysoonercare.org, mysoonercare.org, just how it sounds, and you can kind of see what our front page looks like. Hopefully, you'll go on and apply and probably get denied. [Laughter] Hope so. That's the whole intent, unless you live in Oklahoma. I appreciate it, and I thank you for your time.

DIANE ROWLAND: Thank you, Nico. Now we're going to turn to the State of Colorado and hear what's going on in the State of Colorado.

LOREZ MEINHOLD: Excellent. Thank you. Thanks again, I want to echo the thanks to Kaiser Family Foundation, and Kaiser Family Foundation, Commission on Medicaid and the Uninsured, to our Federal partners, state partners, in these efforts. It's an honor to be here with all of you today.

I'm going to talk about today where we and how we've progressed and move forward. In the chart book, we've made a lot of progress over the last couple years. Really what that relates to is both Governor Hickenlooper, as well as Director Burch, who is our Director of our Medicaid agencies, they understand the critical role Medicaid plays in our state's overall healthcare system, and also a

conviction that we must continue to work to improve, strengthen our system, modernize our system, make it more effective, efficient, and elegant. Those are Governor's three E's that we refer to a lot.

Effective and efficient, easier to understand; elegant comes from the Governor's business background. It is about customer service. It's how do we deliver value and outcomes in our health care system. What this really involves is becoming the healthiest state in the nation, resetting our cost trajectory as a state for Medicaid, and again, delivering on those three E's. We can't achieve this goal unless people have access to health insurance.

What I want to speak to a little bit is the progress we've made. Some of that started in 2009 when we passed our own Colorado Healthcare Affordability Act, where we used a provider fee, basically an assessment on hospitals, matched that to not only increase reimbursement to hospitals, but also expand coverage. It's how we are able to start our adults without dependents coverage in our state. It was the way we expanded our CHIP coverage to 250-percent of Federal poverty, our parents from 60-percent to 100-percent, and that's made a real difference in our state. It's why the progress has also been around the creating of a state-based exchange.

We were recently certified conditionally as one of the states to move forward. We did that with bipartisan support. It is the progress we've made on identifying and enrolling eligible children. We recently received a CHIPRA bonus, and I also thank our

Federal partners for that, the largest this year of $43 million, as well as the Governor recently announcing that we would move ahead with the Medicaid expansion envisioned in the Affordable Care Act.

We did that for a variety of reasons, but one, it increases the resources available in our state for healthcare. It allows us to go beyond what we did with our Affordable Care Act to actually cover an additional 160,000 people in our state. It's a recognition that an investment in health care is an investment in the economy, that healthier Coloradoans are more productive workforce, that hospitals will also experience less uncompensated care. We've already seen that through our initial expansions; that hospitals have said, especially our rural hospitals, have seen a reduction in their uncompensated care. This actually has an impact on the rest of our health insurance premiums and costs in our state.

We do know from our previous expansions, as well, that kids with coverage do better in school, that adults with coverage are more likely to receive preventative care. Simply put, healthier people means it costs us less as a state. There's a real incentive for our state as we move forward.

Again, what you'll never hear us do is talk about coverage without talking about cost containment. We have to modernize our system. We have to become effective stewards of our dollars, and so we have several initiatives going on. One includes delivery system reforms. We've been making investments in care coordination, and

through those investments already, within a year, we've seen reductions in readmissions and imaging.

We're reforming the way we pay for care, so that we don't pay just for volume, but value. We're redesigning our Medicaid information technology infrastructure. We're looking to Oklahoma and our other partner states to figure out how we do this. We're not doing it on our own, but really building off the great work being done by our partner states. We couldn't do this without our partner states.

We're looking to enhance the value of services offered to make sure that the services we pay for are cost effective and clinically appropriate, and looking to redesign our administrative infrastructure. Again, the great things that both Cindy and Nico have talked about; how do we do a better job with the resources that we have? We believe and have shown that we can expand coverage and reduce costs at the same time.

Truly, what I'd go back to is the stories, what this means for Coloradans. That's what the governor looks at. These are great numbers, and it's important to contain costs, but how will it impact hardworking Coloradans? A family of five we have that lives in Montrose where the kids have had health insurance, but the parents haven't had it for four years, this means the difference in coverage. It means that they'll have access to preventative services. Our childcare workers, who have a passion to working with our children,

but their job doesn't offer health insurance, nor do they have enough income that will help them purchase private health insurance. Our 19-year-old person who has been on Medicaid, but because they've turned 19 no longer have access to coverage, but their health care needs didn't change when they turned 19. Really understanding that impact that it has on everyday Coloradans is really what makes this important.

We did this not alone. We did this in partnership. When we made this announcement, it wasn't just us standing up there, but advocates. We had businesses standing up there. We had providers, and we had insurers. Again, when we were talking up there and as we were announcing this, a provider shared that Medicaid makes a difference in the lives of the patients and a difference in their lives. As we do this, it's not just expanding coverage, but making sure we have the provider network that supports it, so everything we do is in partnership.

Many states are still in the process of determining how they're going to move forward with the expansion. A lot of it means we have to look at the state budget and how this will work. In Colorado, the expansions will be paid through through the enhanced match, through our provider fee expansions, and our cost containments. Key to the decision is this partnership with the Federal government, is looking at that funding mechanism and making sure that they'll continue to be there.

Our pledge, as we continue to move forward, not to just our Federal and state partners, but is to continue to move ahead with the public/private partnerships. That's key in what we do in Colorado; bringing the populations in our program in a modernized way, bringing it into the 21st century, which is an advancement, because we have some systems that are much older than that; date way back. Gain greater value, continue to cover our neediest, and saved resources in the systems to cover the cost of these expansions. We've done this through the bold and realistic visions set by both the Governor and Director Burch, and so it's truly, again, an honor to be here. We learn from each other and partner with each other as we move forward.

DIANE ROWLAND: Thank you. I think our panel has clearly demonstrated that a lot of what we do in the future depends on how we've built on the past. I think you've heard both from our panelists, from our survey reports about the building blocks, as Cindy so aptly put it, that had been in place for many years and a vision now of how to go forward for the future. I can't help but reflect that while Cindy talked about radios and music, I remember when we talked about Medicaid eligibility being in shoeboxes in the states and that if you had to go find an application, it was in the shoebox, and maybe we've gone from shoeboxes to smart phones, and really trying to connect.

I think the most important thing we hear is that, on the ground, the states are moving forward to make sure that the systems

are in place and that the experiences for consumers at the state level are now able to really bring them the kind of coverage and the kind of consumer-friendly environments that have not always been the history of Medicaid eligibility.

With that, we'll take any questions. We know we've run over somewhat with our time, but we have a few moments for some questions from the audience. If you could raise your hand and also identify yourself when you poise your question, and please try and keep them brief so we can get a few in.

AMY SUTTLE: Amy Suttle, from [inaudible] Research Group. My first question is for Samantha. As states look to expand or consider expansion, can you discuss any potential cost containment efforts that they'll also look to in the FY14 budget cycle? Then my second question, if you'll take it, is for Cindy Mann and talking about the Medicaid drug benefit and the CMS' average acquisition cost survey and the timeline and process for states in adopting that potential process.

SAMANTHA ARTIGA: I'll start with a very brief, but then I'll probably let Cindy chime in as well. We're just getting started looking to see what states are going to do in this next budget session, so I think it's a little bit early to say exactly specifically what this cost containment mechanisms they might be looking at. I will say, over the past year or two in particular, we've seen a lot of state interest in looking at benefit and delivery

system redesigns and thinking about how they can both achieve better quality care at a better value and looking at how they deliver their care, how they pay for their care. If I had to guess, I would say that will probably be a likely area of continued interest, but Cindy may have more concrete comments.

DIANE ROWLAND: Since Kaiser likes to do 50 state surveys, it gets great cooperation from the states. We also have a state budget survey that was released in October that really gives you much more detail on many of the challenges the states are facing, but especially their cost containment efforts.

CINDY MANN: Just briefly on that point, I would say really over the last year, states have turned from some of the more immediate budget cutting devices that states have used in the past for Medicaid and focused much more on service, delivery, and payment reforms that can achieve better coordinated care, better integrated care, and through those improvements, achieve cost savings. It's not that anybody didn't want to get to those changes sooner, but sometimes the exigencies of the budget pressures a few years ago just made it really difficult. Clearly, that's the direction where states are going right now. There is no one size fits all, and there's a lot of experimentation going on all around the country on those initiatives.

Briefly on drugs, we have a MPRM proposed rule on drug pricing and how states can administer their portion of their drug

program in a cost effective way. States are moving forward. Many states are using actual acquisition as a measure for their pricing. We have done a first time ever survey of drug prices. We have made those available to states and to the public to really try and help everybody achieve some greater transparency and efficiency, so we're working on our final regulations. You'll be seeing those come out sometime soon.

CINDY PELLEGRINI: Good morning. Cindy Pellegrini with the March of Dimes. Thank you for what looked like two wonderful reports and a really excellent panel discussion. One of the areas that the March of Dimes is going to being paying most attention to in the next few years is the impact of Medicaid expansion on women of child-bearing age. As you know, in most states, women don't access Medicaid coverage until they get pregnant, and they lose it 60 days postpartum, so we're really looking at the impact of access to care now for those women in preconception and intraconception periods, and then hopeful healthy pregnancies and healthy babies. Can you tell me then are there areas that you are anticipating we can expect either changes in health spending, savings, or perhaps increases, or changes in health outcomes that we should really be paying attention to like maternal and child health as Medicaid expansions move forward in the states?

CINDY MANN: I'll say a few words and actually Lorez may want to jump in since they've done also the early expansion.

I think the point you're raising about pregnant women and women of child bearing age is really important, and it relates also to the point that Lorez made about the 18-year-old who turns 19. There is a gap in Medicaid eligibility, but people who fall within that gap are generally not strangers to the Medicaid program. They are the kids who, one birthday later, become ineligible. They are the women who we cover when they're pregnant and then stop covering 60 days postpartum. In many states, because of those eligibility gaps, they are the 50, 60 year old couple who we cover when they're 65 or when they're disabled, but who stay uninsured during that period of time, if they're considered to be so-called childless adults. There's a great deal of sense to closing those gaps and making sure that there is a continuous source of coverage for people, so that we can really focus as a nation on delivering better quality care and through those quality improvements, think about lowering cost.

LOREZ MEINHOLD: I would just add it's exactly what Cindy said in that this is really about not giving somebody coverage because they're pregnant, but giving coverage to a person because they're a person. It's getting them coverage prior to being pregnant. It's making sure that women get and one of the metrics that we use and look at is what's the number of women actually getting care in that first trimester? We know if they don't that there's worse health outcomes. It really is about getting them

access to care and access to those preventative services, improving our enrollment and eligibility services, so as soon as somebody becomes eligibility whether that be for Medicaid, CHIP, and/or the exchange that they are enrolled, eligible, and then connected to a medical home and getting coordinated care. That's what we found as a state that really helps improve outcomes, not just for a pregnant women, but for a woman, for a man, for a child, for a Coloradoan.

REBECCA ADAMS: Hi, Rebecca Adams. Thank you so much for doing this. This is great. I wondered if you could provide any more details or statistics about the progress that states are making in preparing to comply with the simplification and the expansion, if they choose to pursue that. Of the 42 states that have moved forward, how many are close to completion, and how many might be testing their beta version soon, and are they meeting the anticipated milestones?

On the policy side, I wonder if you could talk a little bit more about how difficult it might be to convert to some of the procedures that are required, such as moving to MAGI. I was struck by the fact that 24 states are still using or still requiring asset tests for parents, so how difficult would it be to change that? I wondered if you had anything more you could share in turns of measuring the progress of states. Cindy, I'd love if you could talk about that and anyone else who wanted to jump in.

CINDY MANN: There's a lot, obviously, going on, and every state started at a different place, and every state's trajectory, as they're moving forward, is, of course, a bit different. Some jumped out of the gate on March 24, 2010. Some waited a bit, but as indicated by the number of states that have, for example, either approved grants to use the 9010 dollars or some of the data that you see in the Kaiser Report, I will say every state is moving forward. There is a lot of accelerated activity going on. There's a lot of ways in which states are borrowing from each other. We're trying to do quite a bit to facilitate that, to identify states with the same vendors and the same general objectives as to how they are constructing their system, the same starting place in terms of their IT platforms.

I think that any sense of milestones, we're revisiting it weekly, because there's a lot of changes going on and a lot of acceleration going on in different ways. There is a lot of changes, but some of it has been paved the way. As you note, some states have not dropped the asset tests for parents but they have for children, and so they know how to do that. They know how it's done. The new application will be a model for them to use; either they'll use it directly or come up with their own. The changes in applications, states don't have to reinvent that; the history of what to do in terms of programming their systems for changes, many of which have already been adopted in the kids context and now gets carried over to

the parent context. Where we can, for example, in the conversion from net income standards to modified adjusted gross income standards, we're really trying to provide a lot of direct technical assistance and technical support. Our guidance issued in December around conversion to MAGI, it's a page turner. You probably have all read it many times.

What you'll is that see we understand it's a lift. We did a lot of work with our contractor to test methodologies, and then we thought we should make our contractor available to states to make sure that they could get the help they needed to do the conversion. I think we're all pulling together and we'll make it.

DIANE ROWLAND: I just want to add that we're not doing something that hasn't already been done. With the exception of coordination with the exchange, virtually all the policy changes, all of the use of technology exists today in one state or another. As long as we can share those experiences, it really does accelerate that learning curves for those states that haven't made those particular changes. States are working really hard. I think they're optimistic that they'll being in a good place in another nine months.

BRENDA SULICK: Hi. I'm Brenda Sulick [misspelled? 1:21:54] with the National Committee to Preserve Social Security and Medicare. I had a question for the authors of the report. Thank you. It's a wonderful report. Maybe this information is in it, but as 20 plus states are moving forward in 2013 or '14 with the dual

state, dual eligible demonstrations, I was wondering if in your interviews, if any information came up about enrollment policies for those folks who will be getting Medicaid and Medicare, and how that would be seamless for them, and how they're preparing for that.

SAMANTHA ARTIGA: We don't touch on those issues in this specific report, but we do have other analytic pieces that look specifically at the duals proposals as well as separate pieces that look at how eligibility and enrollment is changing for different populations. I'm happy to point you into those resources afterwards.

ARVIN WALLY: Hi. My name is Arvin Wally from the Center of Medicare and Medicaid Services. Thank you for your time. I had a quick question regarding the incentive for states to expand Medicaid coverage given that, under the Affordable Care Act, a lot of individuals will receive Federal subsidies or tax relief through the marketplaces. What's the reason for a state to expand, given everyone wants more health insurance, that's true, and that improves quality of life. What's the reason for the state itself to expand Medicaid coverage?

DIANE ROWLAND: I'll let others answer, but just to clarify one point, if your income is below 100-percent of the poverty line, in general, you won't be able to get financial assistance through the exchange. For states that don't expand, there is likely to be significant gap in coverage for people at the state's Medicaid eligibility levels for parents, and most states don't cover childless

adults at all between those income levels and 100-percent of poverty, so there will be a gap.

ARVIN WALLY: [Inaudible 1:23:55]

DIANE ROWLAND: That's correct.

ARVIN WALLY: [Inaudible 1:23:58] they will receive Federal subsidies. Is that correct?

DIANE ROWLAND: Yes, if they qualify for the Federal subsidies, they would receive subsidizes on the exchange.

TRICIA BROOKS: The incentive for states is that there's a 100-percent federal funding for the newly eligible. There are reductions in direct service costs, in uncompensated care that will help states to fund getting people who are currently eligible, but not enrolled, into the system. Ultimately, to have a coverage gap at our lowest income families, where the socioeconomic status indicates that these families are typically in poor health, it's really not the values that we hold as Americans. Ultimately, besides the fact that Medicaid expansion is a good deal for states, most of the economic analysis impact studies that have been done in state after state after state show not only that it could be a breakeven for states in terms of the Medicaid expansion, but that trickle out economic impact, which as Lorez pointed out, means healthier people in the workforce. It creates jobs, and jobs create state revenue, and drive economic activity, is an added boom to states. It's really too good a deal for states to pass up.

DIANE ROWLAND: We've clearly shown today that there is a lot of interest in how states are moving forward, and in the ways in which both two things are happening, the modernization of Medicaid for everyone as part of the streamlining of eligibility and enrollment, and the opportunity to provide broader coverage through the expansion.

I want to thank our panelist from Colorado for giving me a new word to use about Medicaid. I've always wanted it to be efficient, and I've always wanted it to be effective, but now I also want it to be elegant. [Laughter] Thank you all for coming, and thank you for this briefing, and thank you to the panelists who came to join us to today. Let's give them a round of applause. [Clapping]

[END OF 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.