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**Stop the Drop:  
Profiles of Innovative Medicaid Renewal Initiatives and  
Lessons for 2014 and Beyond  
Kaiser Family Foundation  
May 14, 2013**

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[START RECORDING]

**RECORDED MALE VOICE:** Ladies and gentlemen, thank you for standing by and welcome to today's presentation. During today's web seminar, attendees will be in listen-only mode. If you have a question during the presentation, you may submit it online at any time by entering it in the Q&A panel located at the lower right corner of your screen. Simply type your question into the rectangular space provided, select all panelists from the drop-down, and click the send button. It is important that you leave the default selection to all panelists so that your questions get the attention they deserve. Your questions will be addressed at the end of the presentation, time permitting.

As a reminder, this presentation is being recorded. If you are experiencing technical issues, please contact WebEx technical support at 1-866-229-3239.

Our moderator for today is Samantha Artiga. Samantha, please go ahead.

**SAMANTHA ARTIGA:** Thank you. Good afternoon everyone, and thank you for joining us today for your Kaiser Commission on Medicaid and the Uninsured webinar Stop the Drop: Profiles of Innovative Medicaid Renewal Initiatives and Lessons for 2014 and Beyond. My name is Samantha Artiga with the Kaiser Commission on Medicaid and the Uninsured, and I would like to

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welcome you to this next webinar in our Getting Into Gear for 2014 series that examines key implementation issues as we move into the final stretch of preparations for the 2014 ACA coverage expansion.

We are hosting today's webinar because while there currently is significant focus on enrolling eligible people into new coverage options that will become available in 2014, it is also very important to plan for how to keep eligible people enrolled in coverage over time through successful renewals of coverage. Today, we look forward to hearing about some great innovative Medicaid and CHIP renewal initiatives already in place today and discussing some of the lessons learned from these initiatives for 2014 and beyond.

We have a wonderful panel to lead us through this discussion, who I will introduce shortly. First, I want to go over a few additional housekeeping items. As mentioned, this webinar is being recorded, and both the recording and slides from the webinar will be made available after the event on our website at [KFF.org](http://KFF.org). Our goal is to leave room for questions and answers following our presentations, and we will be accepting questions through the Q&A function of the webinar, so you should feel free to submit those as we proceed. I do warn that we have a lot of folks listening in today, so we will be unlikely to get through all of them, but we will do the best

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that we can. Lastly, if you are having technical questions you can also seek assistance through that Q&A function.

Now, to get started, we know that looking toward 2014 the ACA's Medicaid and exchange marketplace coverage expansions provide an historic opportunity to increase coverage for millions of individuals. 2014 will also usher in new streamlined enrollment and renewal processes that are intended to make it easier for individuals to both get and keep coverage over time.

We know from past Medicaid and CHIP experience that getting people through the front door is not enough. Some states that achieved significant success with enrollment learned that they were still losing many eligible people at renewal because they either were unaware that they needed to renew their coverage or had problems successfully completing the renewal process. These losses in coverage at renewal lead to coverage gaps that have a variety of negative impacts that you will hear more about today.

Recognizing this problem, innovative initiatives to increase renewals and promote more continuous coverage have emerged. Today, we are going to dig into learning about why renewal matters, and some lessons learned about how to increase retention in coverage. First, we will hear from my colleague, Jessica Stephens, who heads the Kaiser Commission on Medicaid

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and the Uninsured, who will provide an overview of the importance of retention and the new Medicaid and CHIP renewal processes that will go into place in 2014.

Next, we will hear from Diane Batts, Medicaid Deputy Director with the Louisiana Department of Health and Hospitals, who will highlight the state's experiences and successes in streamlining and simplifying its renewal policies and processes over time for both families and enrollment workers.

Next, Philip Bergquist, Manager of Health Center Operations and CHIPRA Project Director with the Michigan Primary Care Association, will describe an exciting new renewal initiative they have implemented that provides automated technology-based renewal reminders and offers renewal assistance to families.

Finally, we will hear from Njeri McGee-Tyner, Eligibility and Enrollment Director with the Alameda Health Consortium in California, who will highlight their efforts to provide language-accessible and culturally competent renewal education, outreach, and assistance to families.

Now, I would like to turn things over to Jessica to get us started and I will just remind you again to go ahead and submit any questions you have through the Q&A function as we go. Looking forward to hearing all of these great presentations. Jessica?

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**JESSICA STEPHENS:** Great. Thanks, Samantha. As Samantha noted, there has been a lot of focus on getting individuals enrolled in coverage, which is important to enable them to get the care that they need, but we also know that retention matters. It matters because continuous coverage increases quality of care and access to care and reduces healthcare costs, and research shows that reducing turning on and off coverage results in administrative savings.

In thinking about how to improve retention, past data experiences with Medicaid and CHIP provide some key lessons, some of which I will touch upon briefly and which we will hear more about from our other panelists. We also know that the Affordable Care Act builds on these data efforts to simplify the Medicaid and CHIP renewal processes.

Starting, what do we know about coverage and retention today? We know that there is instability in Medicaid coverage over time. A large share of individuals that enroll in Medicaid subsequently disenroll, often within a relatively short timeframe. What you see here is that within two years after enrolling, which is the orange bar represented on this figure, more than half of adults and over a third of children in this study disenrolled from coverage.

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Research also shows that a majority of those that disenrolled from Medicaid either re-enrolled in coverage within a short period of time or become uninsured.

In Figure 3, we see the insurance status of adults and children just six months after enrolling from Medicaid. Here, a relatively small share, as represented by the dark blue bar, gained other insurance coverage in that six-month period, but two-thirds of adults and more than 7 in 10 children either re-enrolled within six months into Medicaid coverage or they became uninsured.

Why does this matter? We know that this matters because individuals with recent gaps in coverage receive less care than those that are continuously insured. Compared to those with continuous coverage, represented by the dark blue bar on the figure, individuals with a recent gap in coverage, the light blue there, are twice as likely to have gone without needed care and more than twice as likely not to have a usual source of care. We also see that those with a recent gap in coverage are more likely to depend on the emergency room as their usual source of care, or to have gone without a doctor visit in the past year.

Retention also matters because it has an impact on healthcare costs. We know that costs are higher for those without continuous coverage, and expenditures—Medicaid

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expenditures decline as enrollment lengthens. Here you see that the average Medicaid cost for those on coverage for a full 12 months are about half of those that have had coverage for only one month of coverage. In addition, you add in the administrative cost of re-enrolling those that lose coverage.

Now, South Carolina serves as a good example of the importance of retention and steps that states can take to facilitate renewal. In 2011, South Carolina initiated a data-driven analysis of retention in its Medicaid program and found that 140,000 children lost coverage and most returned within a short time. Here, you see children represented here as the 140,000 children that lost coverage. The state found that 90,000 of children, nearly two-thirds, returned within a year after losing coverage, and 60,000, about 4 in 10, of those children, returned within just the first month.

This churning on and off coverage resulted in administrative burdens for families, administrative staff, and providers. To address this issue, South Carolina implemented Express Lane Eligibility at renewal, which is a process which we will hear more about, that they use data from their state's SNAP and TANF programs to facilitate renewal of thousands of uninsured children into coverage. To that, they were able to recoup significant savings in administrative time and costs,

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including 50,000 staff hours per year, a million dollars, and additional beneficiary and provider time and costs.

Like South Carolina, many states have simplified renewal processes, particularly for children. Almost all states currently offer a 12-month renewal period, and most have eliminated the in-person interview requirement.

About 20 or so states currently do administrative renewal, which is a process in which they send a pre-populated renewal form to families that they have to then either sign and return or take no action if nothing has changed.

A number of states have also implemented continuous eligibility and Express Lane Eligibility for children, and a couple of states have also implemented those two options for adults through waivers.

Finally, we know that the ACA builds on state efforts to simplify the Medicaid and CHIP renewal process. As for most populations under the Affordable Care Act, all states will be required to move to a 12-month renewal period. They will no longer be allowed to require in-person interviews, and the Medicaid and CHIP agency will need to evaluate income and other beneficiary information through third-party data sources to determine continuing eligibility before requiring any information from the beneficiary. If that is sufficient, the agency can then renew coverage.

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If they cannot determine continued eligibility based on the available information from third-party data sources, they can then send a pre-populated renewal form to the applicant or to the beneficiary at that point, with 30 days to provide information. The beneficiary then has the ability to provide that information through multiple means, including by phone, online, in person, et cetera.

Once that person provides the information, if it is sufficient to continue eligibility, coverage is renewed. If they find that the person may be eligible for another coverage program, it may be transferred to that coverage program. Only if that information is not provided is notice provided and coverage terminated.

However, the ACA also includes a provision that says that if the enrollee subsequently responds after losing coverage within 90 days after termination, the agency can then renew coverage without requiring a new application.

**SAMANTHA ARTIGA:** Great. Thanks, Jessica. Now we are going to hear from Diane Batts in Louisiana, who is very far along the lines in terms of implementing policies that closely mirror where all states will be headed with their renewal policies in 2014. Diane, tell us about your experiences there.

**DIANE BATTS:** Okay, sure will. Thank you so much. Okay, on our first slide this kind of gives an overview of the

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changes that Louisiana has made to improve retention over the past 15 years. As with most states in the 90s and early 2000, we were losing more kids at renewal than we were adding, so we knew we had to make some changes, but change was not easy. We had not heard of things like process improvement, WorkSmart, transparency, or simplification. We thought that we were performing the best we could, but really we were working hard at just working hard. Today, we still work hard but we work smarter.

On the next slide, Ex Parte really opened the door for us to use other systems to obtain information instead of requiring the applicant to provide it. When we implemented Ex Parte renewals back in 2000, we put a three-month moratorium on closures while major policy and procedural changes were developed. We conducted in-person training for our staff, instead of just sending out notification because we felt it was important for them to hear and understand the expectation that this new process must be fully utilized.

We also implemented verification requirement changes that allowed for self-declaration of residents instead of having the applicant provide that light bill at every renewal.

About the same time, we adopted a pretty radical change that we called reasonable certainty. It took workers by surprise, but they eventually caught on, and we provided

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examples such as someone who was working at McDonalds for 20 hours a week was not likely to exceed the income limit for a household of three.

We also modified procedures in 2001 to require aggressive follow-up when people did not return their renewal form. It became mandatory for staff to make at least three phone attempts and document those calls prior to closing the case for procedural reasons. We even had supervisors that would stay late and make phone calls themselves.

We started getting field offices involved, setting goals and challenges for them. The regions were asked to design and implement projects to improve renewal outcomes and best practices were shared amongst the regions. We held meetings and conferences and encouraged the regions to do the same.

Some of the projects that were tested in the local offices proved successful and eventually became part of our policies and procedures, and that is how telephone renewals began. In 2003, after testing this option in many of the local, small-scale tests around the state, the agency implemented telephone renewals as an option when Ex Parte could not be done. It started with the analyst conducting random calls to try to reach the customer, and later changed to a more

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effective process where the analyst sends a letter to the customer telling them that it is time to renew, please call me.

In 2006, we implemented the automated voice response renewals. This allows families to renew any time, day or night. They can call our toll-free hotline, select the option to renew by phone, answer just a few sets of questions, and the system translates what the caller says to text, and the renewal is routed to the appropriate eligibility office for processing.

Then, in 2007 we conducted extensive data analysis to identify cases with very low likelihood of closure at renewal—for administrative renewals. We found that we were spending a lot of administrative effort to conduct full renewals on cases that just simply did not close. We sent a letter that asked us to call us if their income or household membership changed.

Next slide.

Calls are directed to our customer service unit, which provides additional relief to our local Medicaid analyst. Next slide, please.

Our latest effort to improve our renewal efforts is what we call Express Lane renewals. Each month, we send a file over of individuals that are up for renewal the following month to the SNAP agency. The SNAP agency bumps the file against their system and they return a file to us the following night, indicating if the individual is eligible for SNAP. Children

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that are active SNAP, they are automatically renewed for 12 months. The parents do not have to take any action.

The next slide just shows the various methods that people in Louisiana are renewing their Medicaid and CHIP coverage. You will see that we have very low usage of the form. The majority of our renewals are conducted electronically.

This next slide is just a snapshot of what we call our workload. It shows that fixing renewals really does make a difference. We were closing approximately 22-percent of our renewals for procedural reasons in 2001, and today we close less than 1-percent. We have lost 250 staff in the eligibility division in the last five years. That is a 26-percent reduction in workforce, yet our enrollment continues to increase. There is no way we could have handled this increase if we had not implemented these procedural improvements.

On the next slide, organizational change is the major factor in simplification. You have to have buy-in from your front-line staff, or it simply will not succeed. It took internal marketing on why health coverage for kids was important to our children, our families, and our state, and we found that empowering the front-line workers to make suggestions and test their plan, analyze the results, and they were able to see how change was important. Although they

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started out thinking we are already working smart, they were able to see that there was still room for improvement. They were able to complete renewals well in advance of their deadlines. They were able to identify and eliminate unnecessary work, reduce paperwork, and see even fewer procedural closures at renewal.

The next slide just gives some lessons that we have learned. We know that some policies and procedures have unintended consequences. The main thing is that you try, and if it does not work, do not just keep doing it because the policy says so. Change it again. In Louisiana, we seem to be change managers here. We live change, as with most states do.

Share best practices and reward good outcomes. Remember that your front-line staff have unique insights, so encourage them to talk and be willing to listen when they do. Define the degree of risk that you are willing to take, and let people know why you are doing it, no matter what it is. Everyone wants to be included and feel a part of the process, and have investment in making things succeed. Expect push-back, but be patient. It is worth it. Thank you.

**SAMANTHA ARTIGA:** Okay. Great, Diane. Thanks so much for those lessons learned and that great experience you are having there in Louisiana. Now we are going to turn it over to Philip Bergquist, who is going to tell us about some exciting

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new work they have underway in Michigan to help families keep coverage there.

**PHILIP BERGQUIST:** Thanks, Samantha. This is Philip Bergquist from the Michigan Primary Care Association. Just wanted to give you a little bit of background to get us started.

As a primary care association, MPCA works primarily with community health centers across the state, and as an organization we focused a lot on access to care over the years.

One of the areas that we have been really interested in, especially as an organization that has done a lot of work in enrollment, was actually retention. We saw, anecdotally, in our experiences, that many of the people that we were enrolling had been previously enrolled in the program and had dropped out at some point or another, which really speaks to the data that we saw at the beginning of the webinar.

We took it on and decided to write one of the CHIPRA grants to test a new theory around how we could improve retention. We selected nine health centers to work with us that represent a mix of urban and rural areas, and a very diverse patient base. Within that group of health centers, serving almost 100,000 Medicaid and CHIP beneficiaries, there are many folks that speak English as a second language, pretty significant health disparities, and different racial and ethnic

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groups, each with their own kind of unique perspectives on the Medicaid program.

On the next slide, in one quick and concise thing, this is what we do. This is sort of the model that we are testing out in Michigan. It all starts with a text message. Just to kind of give the background on this, what we were looking for was a methodology for community-based organizations and healthcare providers to take a bigger role in helping people retain coverage. They were doing a lot, and certainly MPCA and members have been doing a lot in terms of enrollment, but previously had not done a lot in terms of retention, so we thought what is a good way for us to get involved with coverage retention, and what is a cost-effective way to approach it?

That is actually how we came up with the idea of using automated messaging systems like text and voice messages, so in the beginning of a month, clients received a text message before the month they are due to renew. They have the opportunity to reply to those text messages, so they can always say stop and get removed from our list, and then folks can reply renew and actually have a text message conversation back and forth with project staff about how to complete the process, and we will refer them to resources, to a place where they can print a new renewal application, where they can do it online, kind of answer the basic questions via text message.

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The folks that do not respond to our initial text message receive a voice message later in the week. We like to screen out the people that did respond so that we are contacting them the least amount as possible. We definitely want to make sure they hear that renewal reminder message, but we do not want to send them too many messages, so we screen out and focus down our group for each message.

Then, finally, the people that do not respond to our first text message or our voice message get one final voice message during the month their child's insurance will expire. In all of these messages, we offer assistance either on the phone, via text message, or in person at their health center.

We had to do a lot to prepare for this type of program, and I will say a lot of the things on this slide say agreement after them, and what we embarked on was a very different data exchange and matching process, so to get all of the data that we needed to follow this group of beneficiaries to make sure that data was secure, used appropriately, and that it was updated on a very frequent and reasonable basis, we wanted to make sure that all of these agreements were in place with our state Medicaid agency, with data contractors, with each of the participating health centers, and then also, for the purposes of HIPAA, privacy and security business associates' agreements to govern the use of all of that patient health information.

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We designed a data exchange and matching process that works through our state data warehouse. It was the simplest approach that we could think of and a very sort of bottom-line answer, which was after that child's renewal date, do they still have coverage? That is how we are looking at retention for the purposes of the project.

We vetted quite a few different vendors for developing our messaging system, developed a database system to house all of this information in a secure manner, and then also have done quite a bit of training to get folks up to speed and very comfortable with these processes and the messaging so that they are working in tandem with the participating health center systems that they have in place.

I think the next really important thing that we have spent a lot of time on recently is actually about regulatory frameworks. I think everybody knows from having your own cell phone that there is really a considerable amount going on within federal regulations from the FCC and the FTC around how you can use automated messaging. The rules are really broken down into a couple of categories, and I wanted to give people a really good idea of what those rules are and how they apply in a brief time period.

I think the first piece to think about is landlines. Many of our folks have provided landline phone numbers, and we

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will send those landlines voice messages. Landlines—again, they require prior express consents to send that type of message, but there are a number of exceptions. Specifically, four types of calls have been exempted from that rule to have prior express consent, and those are on the slide. I think most of these calls would apply to any type of program that an organization like MPCA and others on this call would be moving forward with, and then those are not made for a commercial purpose, calls made by a tax-exempt non-profit, and then those that deliver a healthcare message.

The next big bucket of rules are really around cell phones. I will say, the cell phone rules are a little less lenient. There are no exceptions, so rules made for calls to cell phones have to have the prior express consent of a called party.

I am going to talk a little bit about what prior express consent means, but I do think that it is important to note that we are viewing these rules through the use of an automated telephone dialing system or a pre-recorded voice, so in our program we are sending text messages or voice broadcast messages, where there is not somebody on the other end of that phone dialing each number. It is actually a predetermined message sent to a population, and that is why these rules apply.

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In terms of express consent on the next slide, the express consent means that whoever you are calling has clearly stated that the entity can call them, and they have expressed an understanding that the next call will be made. Previously, there had been an exception around clients that you have an established business relationship with, and folks that have been around the text and voice message world for a little while may remember that. It has been removed. These calls made to cell phones really require the concept of express consent.

As a resource in kind of developing our program and making sure that we have express consent to contact all of the Medicaid and CHIP beneficiaries that this project services, MPCA has actually posted some sample language and we have provided that to the Kaiser family foundation as a resource for others, if you are interested in that as a starting place.

I think the next really important, and kind of last piece of the regulatory framework that I wanted to talk about today was opt-out. This is something that we have all seen and you actually saw it on one of my earlier slides, but all of these messages, automated systems and messaging programs that we pursue, have to have an interactive opt-out mechanism, so a way for somebody to text back or press a button on their phone so that they can no longer receive those messages if they choose not to. In our experience, we have provided these

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mechanisms from the very beginning of the program. We actually have very few people opt out. Most people are really happy to see those calls and we will talk a little bit more about that in the next couple of slides.

In terms of outcomes, we have had some really wonderful early successes in the program, and what I can say about this graph, just to kind of explain it a little bit, the top green line, that is the group of folks that are receiving renewal reminders, and then also offering renewal assistance within the MPCA project group. The lighter red line that is below it, kind of just below the 80-percent to start, that is pretty much every other child in the state of Michigan.

Throughout the length of the project thus far, the project group that is receiving these reminders and then assistance with renewal if they ask for it, has had a much higher retention rate, and in some cases that retention rate has gotten close to 100-percent, although we are not quite there yet. On average, throughout the course of the project so far, it has been about 12.3-percent higher than all of the other children in the state.

To kind of look at what that means in another way, we were able to kind of average out the difference in retention between MPCA and the rest of the state and look, that dark red line that is right down the middle there, measures our

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performance against retention average for the project group and all of the other children. Again, most of the time the project group that is receiving the renewal reminders and offering health insurance renewal assistance is performing significantly higher. Our goal is to increase the retention rate amongst this group of folks by 20-percent, and that 20-percent over the benchmark from when we started the project.

Now, this is not on the slide, but we just kind of just finalized the data and we have actually exceeded our goal. We are just right around 23-percent, so over the course of the last year and a half as the project has been moving forward, those retention rates have continuously gone up.

The reason that we are measuring a percentage rather than a number of folks is that, as you can see, there are big changes from month to month. One of the reasons that those changes are there is that the number of children that are renewing each month is very different. Some months, our program will have tens of thousands of kids that are up for renewal, and sometimes we will have 5 to 8,000. The numbers have a pretty big effect on what the ultimate outcome is. We measure the percentages so that we can see that as an overall percentage rather than the numbers from month to month.

Another way that we have been tracking success of the project is really based on client feedback. We have gotten

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hundreds of surveys back from children and their parents that are enrolled in this program, and most of them, kind of the vast majority of them, seem to be really enjoying the program.

The one at the bottom is kind of the one that we track most often and the one that is most meaningful. About 85-percent of folks are saying that they would like to receive these coverage renewal reminders in the future. I think that that is a really important lesson.

Going into this project, we were not sure what the reaction would be. It was not something that had been tried before in the state of Michigan. We knew that there would be a lot to adapt to in a different process moving forward, but we have been met with really kind of open arms from the beneficiary population saying that they find them helpful, that they are receiving useful assistance through the project, that they are feeling like they are respected and their privacy is respected, and that they want to continue to get these renewal reminders in the future.

This last thing is some of our key lessons learned. I think one of the most important things that we have done is picked a really great vendor. We watch our statistics on a granular level, really, very, very closely. The vendor that we are working with providing that data is really part of your daily operations when you are running a program like this, so

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making sure you have somebody with great data, great user interfaces, great reporting capabilities is all pretty integral to the success of a program.

When it comes to designing these messages, I would say test them and edit and try again. We have evolved our messages over time and sometimes we will only change one or two words and have a very different reaction amongst folks when they receive them. We have gone through a very iterative process of testing and editing and kind of moving forward on these things.

Anticipate language needs. We are currently doing our voice and text messages in both English and Spanish, and we do that proactively with all of the health centers that are able to provide language needs of their patients.

The demand for in-person assistance is just like enrollment, so people want to talk to somebody about it, and many folks want to do that in person. The highest percentage of assistance in our project is still delivered by health center staff in health centers. We have a nice group of folks that like doing it over the phone and they like the convenience of a text message, but really almost 60-percent is still happening in person, so that is the same for renewal, just like enrollment.

Simplicity has been something that is very important for us. We like to keep something that is very technological

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very simple. Try to send the least amount of messages to achieve the goal, to contact folks in a way that is useful but not in a way that is distracting. I think kind of second to last, the results do take time, so set reasonable goals and, as it was mentioned earlier, iterative change is okay. Sometimes it could take at least two years for the piece to really show up in the renewal results, because as most states are doing 12 months of continuous eligibility, it will really take two of those renewal cycles for somebody to get used to the concept of receiving that type of message and having an offer of assistance.

My last thing before I go would be to say it is really not as hard as it seems. I have every confidence that if you are comfortable sending an e-mail, you are comfortable sending a text message. I know it can sound a little daunting. It sounded a little daunting for me and the staff at MPCA when we took it on as a program, but the technology is very articulate. It is a very, very straightforward, very easy to use piece of technology. It is incredibly cost-effective and we have had really wonderful reactions to it with clients and some pretty great goals and results thus far.

**SAMANTHA ARTIGA:** Great. Thank you, Philip. I do want to mention that we are really excited that today we are releasing a new case study profile of the initiative Philip

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just described. That is available on our website at KFF.org, so you can learn more about the initiative there and see some of the direct languages and messages that they are using as part of that initiative.

Philip, I really want to thank you for pushing us forward into exciting new territory with renewal education outreach and assistance, and finding new ways to utilize text messaging. I think we are increasingly recognizing what an important tool text messaging is going to be for reaching individuals who are going to be touched by the coverage expansion, and I think your experience provides some really important lessons learned about how text messaging can really be effective in helping folks have stable coverage.

Now, what I want to do is turn things over to Njeri McGee-Tyner, Eligibility and Enrollment Director with the Alameda Health Consortium in California. She is going to focus, really, on the importance of making sure that renewal education outreach and assistance is provided in ways that are accessible to the folks we are reaching. I will turn it over to you now, Njeri. Thanks.

**NJERI MCGEE-TYNER:** Hi, thanks Samantha. I am very happy to share today in our retention initiative with you all today. We are the Alameda Health Consortium. We are the association of eight federally-qualified health centers here in

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Alameda County, California. We serve over 70,000 patients enrolled in Medicaid and CHIP managed care plans, and CHIP has now transitioned into Medicaid. For the clinic—for our clinics, Medicaid is the number one source of reimbursement, and retention of coverage is very key to all three entities, our county level, our health centers, and our patients. In our association, we really work hard to established county partnerships for streamlining enrollment into Medicaid and retention efforts, and also just having collaborative enrollment events just to really show how we are working together for the health of our communities.

As you can see here, our patient demographics. 91-percent are below 200-percent of the federal poverty level. 50-percent of our patients are best served in a language other than English, so we are experiencing more patients being more comfortable in speaking with someone or being served in their native language. Clinics employ a culturally-competent staff with language capacity that exceeds 25 spoken and eight written languages.

Then, here we just have a breakdown of our race and ethnicity, 21-percent being African-American, Asian Pacific Islander 21-percent, white 11-percent, Hispanic or Latino is our largest at 39-percent, and then other would be 8-percent. That is our breakdown for our diversity within our clinics.

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In the next slide, so just in reviewing our retention initiative we have had the opportunity within the past three years now to really put some strategies into place that would help patients with maintaining their coverage. I will just speak about right now our renewal notices and fliers.

Basically, we have renewal notices that we mail out 60 days in advance prior to the member annual renewal date. This has been, actually, very successful.

We have a unique color, so the color of the notice is purple, and we just thought that that color would stand out if somebody was to receive some mail. They might not throw that away right away. If it looked like junk mail, they might just open it so we chose the color purple and that has really been actually—had a great impact on response, actually. A lot of patients will call the clinics and say I got this purple notice, so that is something that we thought was a good choice of color.

The fliers that we use are fliers that indicate reminders to renew and what documentation may be needed and how you can come into the clinic to receive help with your renewal application, or you could call us and it gives a visual of what they should expect to receive at the time of renewal, so it would be a visual of what that renewal packet would look like, so they could have a—know what to expect.

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Our renewal notices are in five languages so that we can—those are our five core languages for our Medicaid managed care patients. Each clinic would—we send out a letter in behalf of each clinic where there is a contact name where they can call a specific individual to get assistance with helping them with their renewal.

Clinics are also conducting manual and automated calls, so we notice that those clinics who have the use of automated calling systems there is a great staff reduction of time in reaching members who are up for renewal because those calls can be placed during convenient hours such as in the evening or throughout the weekend. It is more likely that that call will reach the designated member, and it kind of gives them instructions as far as if you need help completing your renewal, please press 1 and it goes in the appropriate language also, based on that member.

There are a few clinics who have education initiatives for their renewal strategies. At one clinic, they actually have renewal education classes, so this has been very useful. This clinic is Asian health services, and they really work hard to meet the needs of the different languages that they serve at their clinic, so one thing that they do for new Medicaid members, they will go ahead and have a class that they will sign them up for that they will come and then they will receive

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instructions on how to complete their renewal, what their process would be, what documents they will need to submit, and just basically trying to guide them so that they can know what to do when the time comes for them to renew. That is one thing they are doing, I believe twice a month.

Also, in their waiting room they created a video that focuses on the renewal process, and I believe it is in two languages. It just repeats in their waiting room as the patients are waiting for services. It just reminds them that you should expect to receive a renewal packet in 12 months and it gives a visual of the required documents, and so that is something also that was very innovative to create, to kind of fit with their renewal strategies.

The 101 assistance that every clinic provides that service, the 101 assistance with Medicaid enrollment and renewal assistance—having that 101 it has really helped build a trusting relationship. We feel that patients are more likely to call that worker back who assisted them with their application if there are any issues or concerns, and then also those assistants being culturally competent and meeting the language need, those workers who can identify with the culture or the language need, it seems like they can better relate to the culture. I am sorry, I had to take a swallow. They can better relate to the culture of the targeted population and

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serve as—to be a good advocate for the patient in addressing the barriers that could come up to assessing or accessing healthcare and social services. Having that—establishing that 101 assistance is very key to building trusting relationships in the community.

We also conducted some staff training, because we felt like empowering the staff to be able to understand and build, what the renewal process—all the details that go into renewing and the documents that need to be presented. If we can better train them and give them the resources and tools that they need, then we felt that it would be more effective in doing that outreach and providing that one-on-one assistance, so we had a training with over—I believe it was 80 staff were trained when we initially started these initiatives, to really prepare them for the work.

Our primary languages for outreach material are English, Spanish, Chinese, Cambodian, and Vietnamese. Those are the core languages that we usually create our fliers and our notices.

Again, our initiatives were initially supported by the CHIPRA outreach grant that we received in 2009, and also the Northern California Region Kaiser Permanente Community Benefits Program that also was a funding opportunity for us to kind of look at our enrollment and retention strategies. Having the

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funding from these grants, it really helped us to develop the infrastructure to sustain our retention initiative, and also to—with this infrastructure it helped prepare us for ACA as far as developing best practices among peer grantees and also just beginning to develop enrollment and retention business models for our clinics.

The next slide is an example, or a sample, of our outreach material. This is a flier that we created under our CHIPRA grant, and basically as you can see here it is really giving a visual in allowing the consumer to relate with not only the language, but also the image that they can relate to. The sick baby, the well baby, well child care, and just overall health needs, dental care.

These fliers were created in two—I am sorry, the ones you have here are in four languages that you see here. Again, we have an image of what the annual renewal form would look like. At the time we had our CHIP program, Healthy Families, but now we no longer have that so new material will just go out with Medicaid information. As you can see, we are really emphasizing not missing the deadline and how we can help you, and please bring your renewal forms in for assistance. Then, at the bottom there, it would give the specific clinic name and a person would be there who are expecting the call so that when

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the patient does call in, they will know exactly what they need and can help them get scheduled for 101 applicant's assistance.

Our next slide—so, basically over the three-year period, this is what our outstanding results have shown for our retention efforts. As you can see, back in 2009 it was very, very low retention rate. We were not—our clinics were not really maintaining our Medicaid patients. We were at 58-percent. As you can see, in 2010 the increase—after one year, we had a 10-percent increase in retention and at year three we were at like a 23-percent increase in retention rates. It is broken out for 2012 by groups, the children, for our strategies that just focus on the kids under the CHIPRA, and then our adults. We show here that even—we were able to maintain a high retention come 2012.

Then, right now, I think it is really—we have not really analyzed it yet for this year, of course, but as of today we are kind of maintaining the same level of retention. We really use this feedback we provide to each clinic individually so that they can kind of see what their retention rate is by—for their own clinic and we can evaluate their best practice that they are using at that clinic and what works well for them and we like to support it with the data that shows well this clinic is doing this specific—this particular

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activity, and their retention rate is very high, or it is very consistent. We kind of use that to gage best practices.

Let us see. Our next slide here—so, some of the lessons that we have learned is that renewal reminder notices and outreach renewal fliers in multiple languages has really helped to increase the response for 101 assistance, so I feel that being able to provide assistance in that person's native language is really key. Patients feel like they can get help from someone who can understand their language or their culture. Consumers are more comfortable asking questions and requesting assistance from staff able to communicate in their native language. Fifty percent of our member clinics' patients are best served in a language other than English, so having the material in multi-languages and also having multilingual application assisters are key to meeting the language needs that can present a barrier to enrollment and retention, maintaining their coverage. We have had—

**SAMANTHA ARTIGA:** Thanks.

**NJERI MCGEE-TYNER:** Yes?

**SAMANTHA ARTIGA:** Go ahead.

**NJERI MCGEE-TYNER:** No, no, no. I was just going to wrap up and say that is our retention initiative and we are grateful to have had this success.

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**SAMANTHA ARTIGA:** Right. Well, thank you all so much for sharing your wonderful experiences and the successes that you have underway with increasing retention of coverage. I will again encourage folks to go ahead and submit questions that they have through the Q&A panel on your computer. We do have several that have come in, so we are going to start to queue those up.

To get us started, why do not we start—for everyone, based on your experiences with retention and the different initiatives and policies that you have underway, what are some steps that states' health centers, other organizations can begin taking today to really help set the stage for good retention as we look ahead to 2014? What should folks be worrying about today as they are planning for 2014 to make sure people keep their coverage? Does anyone want to jump in?

**PHILIP BERGQUIST:** Samantha, this is Philip. I think from a staff training perspective, and this has actually been echoed a couple of times over, one of the most important things that we have shown to be effective is really incorporating the renewal message at the very beginning, so what we are doing in our project really looks a lot at the end of the coverage cycle, at the 11<sup>th</sup> and 12<sup>th</sup> month of coverage, as we call them.

The ability to incorporate patient education, to say to a new enrollee up front that they will have to renew, when to

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expect it, what that renewal form looks like, as Njeri had put on her materials, kind of showing people exactly what that might look like. I think that that is probably one of the most helpful steps. I cannot quantify it, but I can not even count the number of times we have had a one-on-one assistance encounter with a beneficiary and the feedback that we got was I did not know I had to renew. If we could eliminate that, I think that would be a huge step forward.

**SAMANTHA ARTIGA:** Right. Does anyone else want to weigh in?

**DIANE BATTS:** Hi, Samantha. This is Diane. I think it is also important to define the risk that you are willing to take because, like with administrative renewals in our state, we know that there is some slippage, and that we can not get them all but we think it is less than 3-percent that may not report changes as they should, but that administrative renewal notification serves as a reminder. Our Medicaid director is very focused on process improvements, and she has got us all to where we look for ways that we can improve processes, and it just does not make financial sense to spend time conducting a manual renewal on cases that just simply do not change, so I think it is important that you—

**SAMANTHA ARTIGA:** Diane, while you are on that point, can you tell folks a little bit more about how your Ex Parte

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and administrative renewal processes work, and sort of what data you are looking at to confirm folks are still eligible, and how that might change in 2014 looking forward?

**DIANE BATTS:** Sure. For Ex Parte, we have access to multiple data sources, and staff use those first to try to conduct a renewal without making contact with the enrollee. They will check systems such as Social Security administration or workforce commission to get labor information. They also check the SNAP files, and if someone has got active SNAP eligibility, we know that they have conducted a renewal and they have already been through the process of verifying their income so we can get that information from their system.

As we move towards 2014, we will have even more data sources available to us by connecting with the federal hub. We will get that Social Security information where we can verify citizenship, like we do today, but it will be real time. We will have homeland security information and we will also have data through the work number that provides income information.

**SAMANTHA ARTIGA:** Right. You spoke a little bit in terms of the accuracy of your renewals based on using this information. To what extent have you been monitoring any impact on your eligibility error rates, and what have you seen on that end?

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**DIANE BATTS:** We have ongoing monitoring of our renewal activity. We monitor outcomes, we monitor how the renewals are conducted. We spend a lot of time building reports so that we can capture this data, because we know that it is important to retain eligible children and reduce the churn, so we keep a very close eye on this.

Back in 2006, when we had the citizenship and identity dilemma where we were focusing a lot of attention on that, we noticed that our processing times on applications were slipping, so we cut back on some of the retention efforts that we had put in place, and we immediately—because of the reports that we had in place, we were immediately able to see that those renewals were starting to slip again. We were losing kids at a great level at renewal, so we immediately changed our procedures back and we put that focus back on retention efforts because it is just so much more important to keep them enrolled rather than have them fall off and lose access to that healthcare. Like I said, it is very important to keep those reports handy. It takes a little time to build them, but it is worth it.

**SAMANTHA ARTIGA:** Great. Still in sharing, maybe you can speak to how you are, as you mentioned, working with community health centers. Can you speak to how you are sort of determining when folks are coming up for renewal and where you

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are getting your contact information and able to—to be able to provide reminders about the fact that their renewal is coming up, and to what extent you have collaborated with your state to help make that happen?

**PHILIP BERGQUIST:** Sure. I am happy to get started. In our project, we receive the contact information side of our data set directly from health centers, so health centers—and actually, I almost think this is a best practice, even though I did not include it on the lessons learned, but very often the healthcare providers, federally-qualified health centers, health departments, free clinics, the kind of folks that are interacting with this population most often are their providers, and they are also, in our experience, the ones that have had the most up-to-date contact information.

We have a monthly data matching process with the state data warehouse, where we receive the renewal date information, and then we have a quarterly process with the participating health centers where we receive the contact information, and then at MPCA we meld those two things together within one database and put kind of the best pieces of health center information and state eligibility data together as a way to facilitate our reminder processes, and also as a way to make sure that we have really responsive client communications so that we can tell somebody exactly what their renewal date is,

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or when they should be looking at that next year. Those types of questions.

We have had really good luck with receiving that information through our health centers that are participating in the project because they are updating it relatively often when those patients are coming in to see providers of all different types. There are some sort of strings that come with that. There is the exchange of protected health information there, so there is very necessary data security steps, HIPAA, business associate agreements, and also consents from that patient to receive those types of messages before any information is shared.

**SAMANTHA ARTIGA:** Right. Philip, can you talk about—are there other types of organizations that might be able to adopt a similar initiative to what you have in place, and to what extent, have health plans, or maybe even state agencies interested in learning more about what you are doing?

**PHILIP BERGQUIST:** I think this is one of those projects that can really be adapted to any sort of environment, and MPCA's role is really almost as a contractor to all of these local agencies that are directly providing services. We are happy to have received those grant funds and kind of facilitate this program across a broad area. One single organization could take this one. There is really no reason

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that you could not send text messages and voice messages for the client population of one organization or a whole statewide network, and really anybody that has that client relationship and is interested in improving retention could do it.

These systems are very inexpensive, just from a cost perspective, about three-and-a-half cents for a voice message or three cents for a text message, so when you compare them to the cost of even postage without the paper and the staff time to produce letters, there is a huge cost savings associated with it and it is a model that can really be easily replicated in any environment where that information is present and there is a client relationship.

**SAMANTHA ARTIGA:** Great. I guess, shifting gears a little bit, we are getting some questions about what type of help people need with renewal and I am—it is likely to change as the renewal processes get easier in the future, but can any of you speak to—are there any specific groups that seem to experience particular challenges with renewal, or different steps in the renewal process that folks need most help with, and how that might or might not be addressed by the streamlining that will take place in 2014?

**DIANE BATTS:** This is Diane. I feel that some of our low-income working individuals had a challenge trying to reach us during work hours, so the online renewal would give them the

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option to renew their coverage any time of the day or night, and we also have the automated voice response phone system that allows people to answer a few set—a small set of renewal questions over the phone and it gets translated to text and sent to our eligibility analyst to process. It is just a way that we can offer them access after hours because they work and it is hard for them to contact us during the day. We also put on our decision notices and our contact notices, different ways that they can contact us. We have application centers where we contract with community-based organizations to help us take applications, and they can also go there if they need assistance with their renewal, or answering any questions, and they can call us. We provide that toll-free hotline. They can call us anytime during the day and we will be more than happy to help walk them through any of the questions that they have.

**SAMANTHA ARTIGA:** Okay.

**NJERI MCGEE-TYNER:** Hi, and this is Njeri. Also, well, something that we see we have no control over at the clinic level as far as the 101 application assistance—so once the application is turned in the social services agency for the eligibility worker to complete the disposition on the Medi-Cal application and enrollment into Medi-Cal, that follow-up seems to be a challenge.

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If the worker is requiring additional documentation for something that may have gotten missed initially with the application, that follow-up is a challenge with the consumer understanding sometimes what the documentation is or not being able to get the required documentation, or the relationship with the worker may not be as easy to maintain because of the workers—they have increased workloads also, and so sometimes they can not get through to communicate with the worker, and so sometimes we see as a result of that the coverage may lapse or get lost or discontinued.

That is something that we are working in partnership with our county workers to kind of be a liaison for that patient and the social services agency worker, so like if that patient is coming in for an appointment or if we can get in contact with them, we will try to help them get that required documentation so that they can turn it in and get the Medicaid active.

**SAMANTHA ARTIGA:** Alright. Hopefully, some of those challenges will be alleviated as documentation requirements are more streamlined in the future.

Speaking of policies, Diane, on your slide that has a triangle of different initiatives that you have implemented over the years, one key one I think was 12 months continuous eligibility for children, which is an option that states can

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take up for children but still is not an option for results. Can you discuss the importance of that policy, and to what extent you think having that option for adults might be important?

**DIANE BATTS:** I think it is important for all the reasons that Jessica was mentioning early on in the presentation. When there are gaps in coverage, illnesses can go untreated and result in worse health outcomes than if the person had been able to see a doctor and receive treatment at the illness onset. We also have HEDIS measures that focus on keeping people healthy. The way we handle adults just provides episodic care. It is impossible to improve on those measures when there are gaps in coverage that prevent access to care. It is very important that we keep children enrolled because we know that they do better in school and they have better outcomes whenever they have the healthcare that they need, so 12 months continuous eligibility is absolutely important for those healthy outcomes.

**SAMANTHA ARTIGA:** Right. We are coming down to the close of our time, so I want to pose one last question to every panelist here, which is just as we look forward to 2014, what would you say are your top two, three lessons learned about renewal that you want people to be thinking about as they are looking ahead to both their Medicaid expansion and the new

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exchanges. I know you each are in different situations with where your state is on the Medicaid expansion and implementing an exchange, but if you think about the broader audience here, what are some lessons learned that everyone should be keeping in mind?

**DIANE BATTS:** For Louisiana, I think that one important lesson that we learned is that it is important to get your staff involved at every level, from the lowest level to the highest level, because they are going to make or break your process. They are going to help you provide that message, that education that is needed to people. They are going to have an understanding of the reason why it is good for people.

During our process improvement initiatives, we tested many ideas and documented the results and they had a partnership in this and so they were able to see the results and they were encouraged to continue to look for improvements. I think it is important that you involve your staff and you communicate with them and explain why this is good for them and good for the citizens that we serve.

**SAMANTHA ARTIGA:** Phil, what is your top lesson learned that you want folks to walk away with?

**PHILIP BERGQUIST:** Yes, I would say wherever you can, leverage the use of technology to boost retention. Give it a try. We have been able to design a very cost-effective

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approach that clients have reacted very well to, and it is cost-effective not only from the—just how much does it cost to pursue that kind of project, but also in the amount of time that it is saving our staff in creating letters and posting products and all of those sorts of things. Wherever you can, incorporate technology. Know that folks are using it and use it to your advantage as a way to reach more people, reach them efficiently, and keep them enrolled, which is really our ultimate hope.

**SAMANTHA ARTIGA:** Alright. Njeri? Your top lesson you want to close with today?

**NJERI MCGEE-TYNER:** I would say just making sure you have effective messaging that is culturally and linguistically competent and able to reach diverse populations. That able-to-reach part consists of having reliable updated contact data and—because having that reliable data has an impact on the ability to do outreach—effective outreach.

**SAMANTHA ARTIGA:** Great. Well, I want to thank you all again for sharing your time, your expertise, and your great successes with our audience here today. I think there was so much interesting and valuable information shared here that can be applied in many different ways as we look forward to 2014, but also getting started today and laying good groundwork for future efforts.

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I want to thank our audience for listening in today. We hope that this proved useful and valuable for your work. I would ask that if you have the time to please take a couple of minutes as you close out of the webinar to answer the few survey questions that we have at the end, we want to hear about how this experience was for you and also get insight into what future webinars may be of interest and use.

I would again encourage you to go to our website, KFF.org, where you will find a recording of the webinar available in short time, as well as a copy of the slides and a link to the case study profile of the wonderful renewal initiative you heard about in Michigan, and we will look forward to being in touch soon with future webinars.

Take care, and have a great day. Thanks so much.

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