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Audio Conference: Game Change – Health Reform Allows Enrollment in Other Benefits to Leapfrog

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OPERATOR: Elizabeth, the floor is yours.

ELIZABETH LOWER-BASCH: Hi, this is Elizabeth Lower-Basch from the Center for Law and Social Policy. I want to thank everyone for joining us today and particularly for our speakers for taking time out of their very busy schedule to join us.

We've got a lot of ground to cover so we think we'll jump right in.

Today's Washington Post has an article on healthcare reform, "but again, even as President Obama prepares to acknowledge the sixth-month mark since he signed his healthcare overhaul into law, the legislation remains something of a mystery for patients and politicians alike. Its impact is instead being felt largely by state workers nationwide whose job is to implement the law."

So, hopefully this call will clear up a little bit of the mystery and particularly draw attention to a piece that I don't think is gathering quite as much attention in the press which is the effect that healthcare reform could have on the whole veins of benefits and income support that Americans can receive. And also to try and understand what are the processes that are going on at most the federal and state level as we move towards the implementation of this.

While, 2014 sounds really far off in some ways, I know our guests will tell us that it's much sooner than they would like in some ways.

So, I will begin with Kathleen Stoll who is at Families USA and she's really been very helpful in terms of explaining the program overall. So, thank you, Kathleen.

KATHLEEN STOLL: I'm glad to be on the call. Thanks.

LOWER-BASCH: Can you start by telling us some of the big changes that are happening to Medicaid in particular starting in 2014?

STOLL: Sure. Sure. You stole my opening punch line which is going to be the Washington Post story about a state worker in D.C. who was going to get up at 3:15 in the morning to write a grant application for one of the pieces of money that help states plan for implementation. And I thought it really drove home that states are challenges right now with limited resources due to the recession to really move forward.

But let me tell you what they got to move forward on.

The Medicaid expansion will cover an additional estimated 16 million low-income people and what it does is by requiring all states to expand Medicaid eligibility to 133 percent of poverty plus a five percent standard income disregard. And I can talk more about the standard income disregard. But it's 133 percent plus five, so 138 percent.

And it will be available to everyone under the age of 65. We are eliminating eligibility categories of family composition. So, states will be required to cover adults with no dependents.

Now, some low income children who are currently eligible for the SCHIP program, the State Children's Health Insurance Program, will also become eligible for Medicaid. And generally that's a good thing because it provides a more comprehensive benefits package and lower cost sharing limits in Medicaid than SCHIP. So, up to 138 percent for everybody.

The financing of this is that the federal government will pay the full cost of the expansion for all newly eligible Medicaid enrollees for the first three years and then they shift five percent of the cost to the states in 2017 and then out in 2020 it settles in at 90 percent of the cost or 90 percent match.

There are some provisions that deal with states who already have [coverage for] both parents and adults with incomes already up to at least 100 percent because obviously they won't have as many new eligibles who get this full federal match and there's some enhanced match to help those states.

I'm not going to get into a lot of details because I know we don't have a lot of time on this call. And, you know, at first the details can be overwhelming, but a lot of this all makes sense and is logical and fits into place in some good ways so I just – I think getting lost in the details upfront can make you feel overwhelmed.

Now, the income methodology for the new Medicaid expansion as well as for the new premium tax credits that you'll get through the exchange is new. A system called modified adjusted gross income, MAGI. And the idea of creating this new income eligibility determination process for Medicaid is so that it will wind up with the premium tax credit eligibility determinations. And those are available to people between 100 and 33/138 percent of poverty up to 400 percent of poverty.

So, the modified adjusted gross income is designed to help make it easier for states to integrate people who are in the new Medicaid expansion and people who will be in the premium tax credit so that they can go to one place to apply for these programs. And also if they move back and forth between the two programs if their income fluctuates there's some consistency.

I just want to say a few things about it.

First, it's based obviously on federal income tax rules. It's adjusted gross income, that line on your tax form, plus a few other things that generally aren't relevant to low income populations like foreign income. Most of our lower income folks aren't going to have a lot of foreign income. And there is no assets test.

Now, the new MAGI eligibility determination rules will be used for both the premium tax credit and Medicaid except for in Medicaid foster kids, people qualifying for Medicaid under the programs, elderly in disability categories and for people seeking long term support and services.

LOWER-BASCH: OK. Kathleen, I'm going to cut you in because we do have a lot to cover. We did post some links to your paper. To everyone who registered for the call, we can send this paper and any other links you think would be useful.

Can you give us a 30-second sound bite on what the exchanges are and how low income people will be affected by them?

STOLL: The exchanges are new. Well, first of all, states can run their own exchange. They can do multiple state exchanges or they can let the federal government come in and run their exchange for them. And they are really a new regulated marketplace where people can go to purchase coverage that has new rules about how consumers have to be treated fairly by insurance companies and a new central benefits package that has to be covered by the plans.

And the exchanges where you have to go to get these new premium tax credits, they're quite robust. And I can talk in detail about the premium tax credits later if that's helpful.

LOWER-BASCH: You know, is this supposed to happen online or will there be in person assistance to help customers because I know I'm getting confused just listening to it here. And I've been reading about this for the last six months and I can imagine this being pretty overwhelming to a low income person seeking assistance.

STOLL: Well, the idea is that the exchanges will be up and running in 2014 at the same time the Medicaid expansion happens and that there will be a one door entry into both of these programs. You'll go to the exchange and the exchange and whatever structures lie behind it that the state sets up will have to determine if you're Medicaid eligible or premium tax credit eligible. A one-stop shop.

And it should not be complicated. It will be available online. That's required by the law. States also have to provide in-person assistance to help customers with the online application.

There are some provisions that require states and exchanges to develop and navigate our program. Navigators would assist people in enrolling in health plans through the exchange.

It's not so clear they'll be helping people with Medicaid. That's something we're trying to push for but isn't quite clear yet. But the navigators could be a contract that the exchange or the state has with consumer based – community based organization or it could be industry, associations or trade groups, it could be unions, it could be the Chamber of Commerce. So, there's a lot of leeway with who the navigators will be when the state contracts for these services, but the idea is that they should have no interest in guiding people to private insurance and that they're really supposed to help people.

When you go to the exchange you should have a single streamlined form that you applied for. That then allows the exchange to determine if you're Medicaid eligible or if you're premium tax credit eligible or SCHIP.

LOWER-BASCH: OK. Now, currently in a lot of states, possibly all, you can actually apply for both Medicaid and food stamps with a single application and it sounds like they're actually in some ways moving further apart as Medicaid use this new MAGI definition of income. Have you all been thinking about some of this interaction between health reform and other benefit programs?

STOLL: Well, here at Families, I mean, we're low income consumer advocates so we'd like to see what is often called horizontal coordination. But we also understand that the states have a tremendous challenge in getting vertical coordination which is just making sure Medicaid, SCHIP and the premium tax credits and the private market work well together.

You know, I think there's, honestly, some different ideological underpinnings to how states are thinking about this. And I don't mean they sort of repeal republican kinds of ideologies, but really some folks are thinking that this is an opportunity to take Medicaid, SCHIP and the private premium tax credit subsidies and have it be a health program that's not, you know, woven with other low income programs, but sort of its own health program.

And there are reasons why they would like to see that approach. We as low income advocates would rather see more integration, obviously, with other human needs programs so that low income people can use the one-stop shop to not only get their healthcare but find out about other programs.

There's not money in the new law to actually help states develop horizontal integration programs per se. One of the things that we've been thinking about is does it make the most sense as we move forward to keep our eye on the price for 2014 in getting the exchanges set up and the vertical integration between Medicaid, SCHIP and the new premium subsidies very solidly working smoothly. And at the same time, because there are lots of new requirements in the law about data sources that you can integrate and data matching, we need to make sure that we build the system in such a way that then we could quickly move to sort of a second step where we provide more horizontal integration in the new exchange.

It's going to depend on the state. Some states are more ready right now to coordinate both vertically and horizontally. Some states are really challenged to even begin to think about all of the questions they have to set up an exchange.

LOWER-BASCH: OK. Thanks so much.

Two technical things before we move on.

One is that if you, in the audience, have questions for Kathleen or for any of our speakers, please e-mail them to us at audioconference – all one word – @clasp.org and we will be reviewing them and trying to ask our guests as many of them as possible.

We also have been told that the links in the e-mail are not currently working. And unfortunately that's because our e-mail provider is currently down which is causing some trouble. But hopefully, those links will work again in the near future and if not, we'll figure out a way to get them to you.

So, with that technical issue put aside, I think I'll turn to Sam Karp who is the co-chair of a group with a very long name, the Health Information Technology Policy & Standards Committees Enrollment Workgroup. And so, first, Sam thank you for being with us on this call. Can you tell us a little about what this workgroup's assignment was?

SAM KARP: Sure. Good morning, good afternoon, depending on what time zone you're in.

The workgroup was authorized by a section of the Affordable Care Act. For those of you who that want to look that up that's Section 1561. And it was intended for the Secretary of Health and Human Services, no later than 180 days after the enactment of the Affordable Care Act, six months, to develop interoperable and secure standards and protocols that facilitate enrollment in federal and state Health and Human Service programs. So you'll notice that even though this was the Affordable Care Act that there is this broad charge to develop interoperable, secure standards that better facilitate enrollment in health and human services programs.

So, we put a workgroup in place. We got started 120 days into the process. We had a representative stakeholder group of about 20 people. We held eight public hearings, had a listening session for state administration and other officials, and promulgated 10 recommendations on ways in which we thought enrollment and largely health programs but also human service programs could be simplified and better facilitated.

So let me stop with that as having been the charge of the group.

LOWER-BASCH: OK. Now, your explanations we did send around to everyone who registered and they've now been actually accepted with just a few tweaks. I don't think there's anything substantive about changes. Tell me if there is.

KARP: No. No. That's correct.

LOWER-BASCH: And can you tell just a little bit about what the recommendations that you made were and particularly the ones that might affect access for the program…

KARP: Sure. Let me just highlight four of them. Those of you who haven't seen them yet, there are three pages or so summarizing the 10 recommendations and then another 20 pages of appendices. And appendix for each of the core set of recommendations that further describe the intent of the workgroup in making these particular recommendations. So I encourage you to look at them.

Let me highlight four.

The first one is that we took a look at core data elements across the country in 10 states, 38 programs all together to see how states were using core data elements. Things like name, address, social security number, household and so on. And these became important because the core data elements are used for electronic verification. And as you might expect we found a lot of variation in the core data elements.

And we looked at ways that they could potentially be harmonized. Some were low challenges, some were moderate or even higher challenges in terms of standardizing them. But we came up with a standard process for using core data elements relying on something called the National Information Exchange Model.

I won't get into the details of it, but it's a way of standardizing data that's beginning to be used widely in the federal government. Initially in the criminal justice world, but I know the New York City Health and Human Services Department has adopted it and it's being looked at seriously across healthcare clinical information systems.

And why this is important is that the Affordable Care Act requires electronic verification for citizenship with the Social Services Administration, income with the IRS, and legal status with the Department of Homeland Security.

We had all three of those federal agencies in to talk about, "Could you do this in real time?" And they each said that they could. Homeland Security is currently doing it for federal employers right now. The Social Security Administration is doing it in the SCHIP program, in a batch mode for 26 states with a – who have a 94 percent match rate.

But the idea of electronic verification means that applicants are, based on the core data elements, applicants are requested fewer questions and applicants then don't have to provide supporting paper documentation for citizenship, for income based on what Kathleen was saying earlier about no asset test, modified adjusted gross income, and for legal status.

So, if you remove those kinds of questions because you can look it up the core data elements at least for maybe 90 percent of the population and you don't have to ask people to submit the documents you've taken a huge step to simplify the process.

Let me mention just very briefly two of the other recommendations that I think may interest you all.

The first is around business rules. One of the recommendations is that the business rules, in this case eligibility rules, be expressed in what we are calling consistent, clear and unambiguous language. And that they're transparent to consumers by providing understandable eligibility determinations.

I think we all know that there's not much of a rationale provided. You know, maybe you make too much money. But we're requiring that these business rules be in human readable form and that they be separated completely from the transaction system.

And then, lastly, and I think that this is really probably the most significant change, we in the course of these recommendations that now have been adopted and being promulgated by the secretary give new rights to consumers, to applicants similar to the same rights that consumers have with respect to their clinical health information and personal health records or their medical records. Consumers, now, according to the HI-TECH Act that was passed have the right to receive their medical information in an electronic form.

We have extended those rights to applicants and Health and Human Services programs so that they will have a timely electronic access and control on their eligibility enrollment information, to use that information or to reuse that information in applying for other programs. Specifically to be able to designate third party access to family members, to caregivers, to community-based organizations or even providers and that that access can be determine whether it's read only, read and write, read, write and edit, et cetera. These are new writes that applicants and programs will have that we think are pretty significant in terms of allowing people to use their information.

I want to respond to this question of, the ideological – a question that Kathleen raised because I think it's really important to this conversation.

And there are people who are saying, "Let's get this right for healthcare." That there now is an individual mandate. There's near universal coverage. We need to create a more welcoming environment to enroll people in healthcare programs to get away from the stigma of the welfare system which was in tended all the way back to 1996 in welfare reform.

But members of our workgroup who are very consistent, I think, in saying that if a state chooses to have an exchange, as Kathleen said, there's supposed to be a single application. The exchanges are supposed to screen and actually enroll people in programs.

So, if somebody is determined eligible for Medicaid they would be enrolled at the exchange level. That, I think, is still waiting for guidance from CMS, but 20 states today as you all know actually have county administrative welfare Medicaid programs.

So this could be a change in where that eligibility determination is done. And you are not supposed to have to provide any additional information to get enrolled in the program. Many of us believe that if someone becomes eligible for Medicaid that they should be offered the opportunity to apply for other supplemental programs.

And I would suggest that food stamps –SNAP -- is a perfect supplemental program to Medicaid. Once you fill out the Medicaid application they are only four more questions you have to ask for food stamps. The same is relatively true for TANF as well.

Now, because they are different income eligibility requirements and household requirements, it still gets complicated. But I think our workgroup left open the opportunity for exchanges to be able to extend the use of the enrollment information for application and other programs.

So with that I'll stop.

LOWER-BASCH: Thank you so much. And I do encourage folks to look at the recommendations.

And particularly, actually, I think in some ways the fun part is in those appendices. The recommendations are perhaps a little technical. But the appendices have this vision of this great system where you can go and collect all the information they already have and you can check in and change it in a minute. And if you got stuck online you can stop in the middle online and go in in person and then they'll just be able to pick up seamlessly and you wouldn't have to re-enter anything. And for those of us who have spent our lives on the public benefit flow, this is a pretty amazing vision.

So, I do encourage folks to look at it.

Given that so many of these decisions will be made and changed in the state level, what role does the federal government play? And how much are these recommendations really, you know recommendations to the state and how much do they actually force them to make decisions along those lines?

KARP: Well, I think that's a good question and it's yet to be seen.

These are more than recommendations now. Let's go back. The secretary has adopted them and she's promulgating them. And the way they have teeth is if they're tied to money.

So, the states have just been each given a grant of $1 million to do planning for their exchanges. And, you know, everywhere around the country I go I'm hearing state Medicaid directors, insurance commissioners saying, "Where's the money going to come from to build the exchanges, to build this kind of consumer-centric capability into the exchanges to be able to facilitate a more consumer-mediated process. And the grants, I suspect, will come from CMS and I believe they will continue requirements that the standards and protocols generated out of this workgroup will be required as part of the grants that are made to the states.

LOWER-BASCH: OK. Quickly before I turn to our state speakers who will probably have a somewhat different perspective on all this, could you just tell us briefly about the request for comments that was in the Federal Register on August 4 and comments you'll do in a few weeks?

KARP: Yes, these are comments, I believe, generally – Kathleen, if I'm not mistaken, with respect to the exchange?

STOLL: Yes.

KARP: And, you know, this is an opportunity for the public, state agencies, community-based organizations, et cetera to provide their comments to the federal government on the rules and regulations being established for the exchanges. So it's a typical set or a register call for comment.

STOLL: Let me just add that they're due October 4. And Families USA is putting together some materials that will help people think through their 4-5 pages of questions that they've asked request for comments on. So

we're putting together some materials that will be available hopefully the last week in September that will help guide people through some of those questions and share some of our insights on them.

LOWER-BASCH: OK. Thank you so much.

And I'm now going to turn to the two guests who joined us from the states and as we've learned this really is being decided at the state level. And I think they are coming from somewhat different positions and perspectives so I really look forward to hearing from them.

We have Andrew Allison, he is the Executive Director of the Kansas Health Policy Authority, and Jason Helgerson who is the Medicaid Director for the State of Wisconsin. And why don't I turn it to each of you. Maybe Andy first to ask just what your state has been so far in the past six months to implement healthcare reform?

ANDY ALLISON: Thanks, Elizabeth, for the opportunity to share with this group.

Kansas has done quite a bit. I think some other states have done more. We had the advantage of applying for and receiving a grant from the Health Resources and Services Administration, HRSA, to build and really complete our enrollment and outreach process for public health insurance in the state.

We received that funding last year and are just about ready in the next, literally, weeks to issue an RFP or procurement for the kind of eligibility system in Medicaid that will undergo the exchange and accomplish all of the vertical integration in the next three-and-half years that you've already described and that we've heard from others about here, building that system to be expanded later to incorporate also the human service programs, ultimately reaching that integrated vision that I think several have shared today.

So that's been going on since before the bill passed.

Our insurance department which is an independent agency statewide elected office in Kansas, Commissioner Sandy Praeger, is responding to all of the exchange and health insurance reforms that are both taking place and planned. So, submitting a request to the federal government for $1 million in funding to help with technical assistance for the insurance reforms and also $1 million in planning money for the exchange.

The third leg of our activity in the state has been an effort that we've engaged in at the Health Policy Authority to try and prepare policy options for stakeholders and for policy makers. The states will have a tremendous amount of flexibility and choice establishing this new marketplaces and the exchange, and then redesigning the Medicaid program, and then defining the relationship between Medicaid and these exchanges.

We're pursuing private philanthropic dollars since there are no public dollars available in Kansas nor in the Affordable Care Act itself. Two higher consultants, et cetera, developed options for benefit packages and Medicaid, and options to simplify eligibility so that it is easier not only for the families that qualify simply because of their income, but for those other groups that you mentioned and Kathleen mentioned at the beginning of the call who are really excluded from this MAGI income simplification.

It'd be so much easier for states to build the kind of systems we talked about if this were simpler. So, we feel like that process begins with options at the state level that we will then bring to the feds and likely ask for flexibility to implement.

So those three areas really are our focus.

LOWER-BASCH: Before I turn it over to Jason, I did want to just do a little bit of a clarifying question.

When you say that you got funded last year to do this system improvement, this is just the standard matching money for automated systems on the Medicaid? Is that correct?

ALLISON: No. Fortunately not because I think that the standard matching money would probably still be bugged down in approvals especially across federal agencies. That's just my own editorial comment.

We received pure grant funding from HRSA under the State Health Access Program, SHAP, which is intended to expand coverage. There's $700 million plus grant series, 13 states received funding and ours is for a total of $40 million over five years and it was awarded just over a year ago.

And we decided to use our money to expand coverage by actually enrolling the people who are eligible. We also have a small demonstration project to expand coverage to young adults who've rolled off Medicaid. But the main focus is to get those who are already eligible enrolled and in particular the kids.

So that requires, you know, start to finish replacement of our Medicaid enrollment system which turns out to be exactly what's required under health reform.

LOWER-BASCH: OK. Why don't I turn to Jason and let him answer the question.

JASON HELGERSON: Sure, no problem.

In terms of Wisconsin we've been very active under Governor Jim Doyle's direction in healthcare reform for a number of years. We've expanded access through our BadgerCare Plus Program, first all children and higher income pregnant women and also more recently to childless adults through an 1115 waiver. So we've been very active in the run up to national healthcare reform in terms of trying to ensure that virtually all Wisconsinites (our goal is 98 percent of Wisconsinites) have access to healthcare in our state.

That said, once the Healthcare Reform Bill actually passed, which we were glad to see, the Governor two days later through Executive Order created the Office of Healthcare Reform under which we have been working very closely to really begin the process of trying to make sure that Wisconsin is well positioned to implement the many aspects of that comprehensive piece of legislation.

In the case of, I think, the things we're most interested in today is first off the Medicaid expansion which, frankly, in our state has a limited impact because we already cover under Medicaid virtually all the populations

that would be covered in the Medicaid expansion. But in our case, I think the element that we're most focused is really on the exchange and how we in a state with a very comprehensive Medicaid program and SCHIP program, which actually in our state are fully integrated, how do we operate those expanded programs in environment where thousands of additional individuals be accessing affordable or tax credits to help them purchase health insurance through the exchange.

And our approach here and what we're working towards at a fever space is to fully integrate Medicaid and the exchange. We want to create a single front door healthcare. We want individuals to be able to come in, fill out an online application or talk to someone on 1-800 number or meet with someone face-to-face answer as few questions as possible, poll in data from as many trusted sources that exist, to try to make the experience. So, applying for healthcare in our state as simple and as easy as possible.

We've done a lot in Medicaid to streamline and simplify the process. I think we have probably one of the – if not the best – online application tools in the country. Excuse me. And we've already done a number of things that the Bill envisions like the adoption of basically modified gross income.

We actually have a somewhat more gross definition income without asset test and things like that so we feel that, you know, a lot of the sort of lessons or a lot of the experiences that other states are going to experience we've experienced some of those ourselves, but we're excited to go even further and we're excited to be able to see our dream which is to have every Wisconsinite have access and we think the exchange healthcare reform and the ticket to it.

The one final thing I'd say and it relates to Andy's comment about systems which I think is going to be one of the big challenges states are going to have. We actually feel well positioned in Wisconsin because we have a very modern Medicaid eligibility system that we actually just went out for procurement for the main engine enhancement of that system which included the building of the exchange. And so, we plan to build the exchange off of that same eligibility system and that in our view will help ensure that we have complete integration between the exchange and Medicaid.

LOWER-BASCH: OK. Thanks so much.

Now, I'm just wondering if you could speak a little too, how you are thinking about the implications for other benefits, particularly SNAP that we talked about, but possibly other ones – someone send in an e-mail about SSI applications and actually having access to the health information which should be relevant to people's eligibility with that program. Any thoughts about that so far?

HELGERSON: Sure. I can start.

In terms of that, Wisconsin has a long tradition of being a horizontally integrated program. When you apply for Medicaid you're also applying for food share, you're applying for child care now, you can apply for a number of different programs simultaneously.

Our goal is to maintain that horizontal integration, but then also add that vertical integration piece which is the exchange in access to healthcare's subsidies or tax credit for individuals with higher ends of the income spectrum. And so our goal and our belief since we would be building off the existing system, that we have the ability to both maintain our horizontal achievements, but also to build in that vertical.

I think that Andy, the earlier speaker, had mentioned – and I know from my colleagues, talking to my colleagues across the country – there've been efforts in many states to look at the horizontal piece and there's, I know, some concern that there may be some steps backwards in terms of horizontal integration because we're all going to be so focused on maintaining that vertical piece. And, you know, certainly, our hope here is Wisconsin is to maintain both.

ALLISON: And this is Andy. And, you know, many states – Kansas included – are jealous of how far down the path Wisconsin already is and that they can build on the system that they have now to create both the vertical and horizontal integration that I think most of us would agree is the goal at some level.

In Kansas we've come to the very arduous decision after easily hundreds of hours of deliberation over the past year that we have to stage this and that there's just too much to accomplish in the vertical integration to try to add the horizontal in the next three-and-a-half years. But we're explicitly building this system so that it can be added on to attend it and integrate it with human services just as soon as the health reform piece is completed.

And you raise a very good question, Elizabeth. The other component to integration has, I think, maybe more to do with the health information side.

I think Tony Rodgers running the Medicaid program in Arizona was one of the leading states advocating for the use of the application process to collect information on your health status and really to begin a relationship with Medicaid recipients. At the point of application they can draw them to the healthcare that they need.

This obviously relates to the establishment of and contribution to a personal health record. We are clearly indicting in our procurement that that's a goal and that's a possibility and we're anxious to see what we see in the bids.

I think the final point I would make is that we're going to build this system so that it can support the exchange so it ultimately can support human service. The question of just how integrated the consumer experience is will be a policy choice and I don't know what policy choice the exchange in Kansas will make.

I imagine that there'll be some who object to a consumer experience for an applicant to the exchange also being faced with questions about eligibility for human service programs if somehow they haven't indicated their desire to avail themselves of those human service programs. That really is is the consumer experience that the systems underlie this integration, will communicate with each other if in fact they're not the same system. The consumer interface may be fairly diverse based on whether you approach this experience as one interested in the human service program, Medicaid or the exchange.

LOWER-BASCH: OK. I'm going to ask a question that's been submitted by Stacy Dean who is from the Center on Budget and Policy Priorities. She was actually a member of Sam's workgroup, I know, and she's been thinking about this a lot.

Specific question is, if you walk in to a human services agency what is your experience? And it sounds like in Wisconsin that you will be able to apply for both SNAP and health coverage in one place.

And in Kansas, if you walk in to a human services agency, will you be able to apply for healthcare there?

ALLISON: You can now and I expect that you will be able to do that at each point along the way.

I think that while we're creating this new integrated system, there may be some disruption. Now, I would say that our current system needs to be replaced as it is. It's hard to describe our current information infrastructure eligibility process in Kansas as integrated right now. We're going to end up in a better place.

I think the open question is, just how many of the human service locations there will actually be 5 years to 10 years from now. We're going to automate virtually all the Medicaid enrollment process and that may actually lead to a lesser need for that human interface.

We are orienting ourselves in our new system towards community partners and volunteers, healthcare clinics, you know, churches, libraries, public – all sorts of outlets who can facilitate enrollment because they have that Internet access, they have some similarity with a very easy to use interface, that really is the human contact on the medical side that we anticipate going forward.

HELGERSON: And if I could just reiterate, you know, I think that's a very, very important point that Andy just made, is that right now we in Wisconsin partner with 200 community-based partners and we certainly hope and believe that the future is not people accessing "welfare programs" at health and human service welfare offices, you know. And people do find their way there. That is one place where they can be served, but our hope is to have many points of entry for individuals who can work with the other trusted community-based partners or healthcare providers and I think that a simple to use online application tool and training, a myriad or different partners is a way to really get us out of that sort of more of a welfare mentality.

LOWER-BASCH: OK. Picking a bottle point that you just made a few minutes ago that these really are policy decisions about how the online applications will be structured, what the human interaction will be, what are the opportunities for advocates to help influence these decisions? And in particular, possibly advocates who don't spend all their time in the healthcare world and may not be as caught up on all the details with healthcare reform, but do work with low income population.

KARP: I think that there are lots of opportunities for advocates to encourage people, states, and the counties that operate these systems, to adopt some of the consumercentric approaches that are in these recommendations.

You know, today, I think in most states it's really not required that you come in to apply for Medicaid. The Food Stamp program is different although USDA has been granting waivers for in-person interviews and allowing them to happen over telephones in some states.

Continuing to push for the removal of requirements that working families have to come in to welfare office, I totally think Jason was right in the approach, the boat Wisconsin is taking and how he was suggesting that these programs will be designed going forward.

When you look at data from places like the Pew Internet & American Life Project that have been surveying the public for the last 10 years about their Internet use, you'll find that what we all had been talking about is digital divide while it it still exists, it exists to a much lesser degree than it has in the past.

So, low income families of Latinos are the leading in the adoption of Internet access in the country. I saw a survey recently that said that African-American and English speaking Latinos, ownership of things called the mobile web which is an adult laptop or a cell phone with Internet access exceeds Caucasians, 87 percent to 80 percent. So, significant changes in the ability of low income families to be able to access information and services online. You know, we live in a digital society. We ought to be offering these programs in the methods and modes that people are used to interacting with other services.

STOLL: This is Kathleen. You know, I was thinking for advocates who want to be thinking about horizontal as well as the challenges of vertical integration in this range of issues, besides the RFC, the request for comments, on the exchange, there are at least 25 states by our account some sort of public process going forward to start looking at exchange issues and their states submitted on September 1 grants to support those processes. And I believe almost every state applied. There are a couple exceptions. That money will be coming to the states in September or early October and so those give me some opportunity to be thinking about how you can achieve horizontal integration goals.

But I just want to emphasize, and although we are definitely wanting to get there, something a couple of the folks on the call mentioned which is the need for sort of a positive attitude about this is all doable, but also a patient attitude about whether it may be a two-step process to achieve a smooth working system that allows Medicaid SCHIP and the new premium tax credits to all work together smoothly and then maybe in 2015 having built the foundation of information sharing systems, data matching as required in the federal law and going beyond that so that you can easily then start to expand to more integrated horizontal application processes.

Some states are going to be, like I said, ahead of others, but in some states, and there are maybe folks on the call from Georgia or West Virginia, where it's very challenging to think about just getting the exchange and the Medicaid program to work with the premium tax credit. So if you think about the issues just around turning in income variation and how people may be moving back and forth across this program, there's really just a lot of interesting issues. They're challenging, they also have good solutions, they're doable, but a lot of things for states to work through in a time when they may have less resources and less staff than they've had in the past to even work on the health programs they have now.

ALLISON: Kathleen, this is Andy. And I would just give an example of practically what that means in Kansas.

We're going to procure the health insurance eligibility system very soon and the plan in the state is to move directly in the procurement of the rest of that system on the human service side as soon as we know what we have on the health insurance side. So, some of this can actually overlap and as you say go right in to the expansion and extension of integration beyond 2014.

And what I would encourage is that advocates for the human service programs, to the poor in general, try to view health reform and the Affordable Care Act as the opportunity to create leverage for integration that in many states doesn't exist today. I think we can take this question and the possibilities are actually greater with health reform than they would be without. We do have transition issues between now and then, but it's a huge opportunity.

HELGERSON: I would second that. It's the opportunity to simplify that we've all been working on for years.

LOWER-BASCH: Andy, I'm going to quote back something that you said at the conference and I think that's a few weeks ago. Because I thought that it was so great. But you said that you were building round holes to put round pegs into down the road. I thought that was a nice line in terms of describing it.

Kathleen, we've been asked whether you're comfortable offering us some states that you think are most advanced or prepared to do the integration and states where there's maybe more of a challenge? I don't want to put you on the spot if that's not something…

STOLL: Well, you know, you've got Wisconsin on the call and I think they're one of the states that we see moving ahead the most quickly and as a potential model state. And looking at Kansas as a state where the Medicaid integration there could be a model developed that other states could pick up. So Kansas and Wisconsin are on this call.

The other states-- California is moving ahead. They passed legislation to begin the process of setting up an exchange so I think that puts them ahead of the curve.

KARP: Just to be clear about that, it's passed but it hasn't yet been signed by the Governor and there's a lot of opposition by the insurance industry.

STOLL: Imagine that, Sam.

KARP: Not yet a done deal.

STOLL: So, the law at least provides some help.

There are a couple organizations, the National Academy for Social Insurance working with Deborah Chollet and Sara Rosenbaum are developing some model legislation on exchanges that may tackle some of these

horizontal integration issues. That process is just underway to set up that model legislation so that may be a good way for states that are a little slower on the take up to get some guidance that they can pick up.

National Association of Insurance Commissioners will develop some model legislation. I imagine it will be more skeleton in its appearance and provide like you could do this or this kind of alternatives, but I would definitely plug in to the National Academy of Social Insurance's process.

LOWER-BASCH: One more question just particularly to the states about what role would you like to see the federal government play in making this happen? What would be most helpful to you if you proceed? Obviously money is always helpful incentive beyond that.

HELGERSON: Sure, I can start on that.

I've been to quite a few meetings lately with federal officials and states talking about the implementation particularly around the implementation of exchange and the integration with Medicaid and all these challenging topics. And, you know, what you always hear is money and flexibility. I think they are sort of easy things for a state to always ask for. I think regardless of topic you'll hear state officials asking for both and they're important. I'm not going to discount that at all. This is a major list for us and we need help from the federal government.

But the other thing they were trying to do with our federal partners is really engage them as we move forward with beginning to put together our plan for how the exchange and Medicaid are going to be structured and integrated in Wisconsin.

Also, because a lot of these are on uncharted territory, some of the things that are going to be required have never been dome in any state including Massachusetts before. And one of the concerns that I have looking forward is in some cases you don't know what you don't know until you do a little bit more work and research and really diving into trying to address some of the challenges.

And while every one has been asking for the feds to provide guidance I'm actually taking some solace in the fact that we haven't gotten total guidance yet because frankly not everybody knows he answers. And I think that as some of us who are being very aggressive in our planning about how to implement, I think we start triggering some questions ourselves and we communicate those to the feds.

So, I guess, one additional question or what request do we have for the feds in relation to money and flexibility is take a little bit of time before you set your rules and guidance into place to make sure that we haven't identified some problem that down the line that guidance isn't going to look so good. You know, once it's been put into cement.

So, I think that, you know, that would be my one additional request from the federal government.

ALLISON: I would echo everything that Jason has said and add only one based on our experience with the project that we're moving ahead with in enrollment and that is for our federal agencies to work together and to

have a common answer to the question this phone call has raised and that is, how do we achieve integration, do you have to stage it. And what does that mean is the role for the human service components at the federal level now. We don't have time for the bureaucratic issue with their level, they just need to be working on this right now.

STOLL: This is Kathleen. One thing I'd add is that we've been in conversations with HHS, also encouraging them to define at least some of the broad strokes of what the federal option would look like because we're working in a lot of states where the first question is, do we want to even try to tackle developing our own state exchange. And I think there can be a lot of advantages to doing so, but in some states will we just do better to go with the federal option and what would that look like, and then how do we make that work with our existing programs.

So, one of the first things we hope we'll see from OCIIO [the Office of Consumer Information and Insurance Oversight] is, what is this federal option going to look like and so how to start – states begin to take that off the plate as an option for them or to think about it.

LOWER-BASCH: OK. It looks like we have come to the end of our time and so I just want to thank, again, all of the guests for participating and taking the time out of your very busy schedule to do this.

I hope everyone found it interesting. We will post the recording of the call and also all the resources that have been mentioned on our website so that you can follow up on them.

I suspect this probably brings more questions in your mind than we've answered, but hopefully we've convinced you that this is an important topic and want to pay attention to as it plays out in both the federal and state level over the next few years. And my guess is this isn't the last of these audience conferences we'll be doing and as everything develops we'll be checking back into, you know, how it's going. So, thank you all for joining us today.

OK. Thank you very much.

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