ALLIANCE FOR HEALTH REFORM

Expanding Medicaid Programs
Alliance for Health Reform
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EDWARD F. HOWARD, JD: Since so many people are here on time, we don't want to waste your time. My name's Ed Howard. I'm with the Alliance for Health Reform, and I want to welcome you on behalf of our board and our honorary leadership, Senators Rockefeller and Blunt, to this program about the options that states have to expand their Medicaid programs to cover people up to 138-percent at the federal poverty line. Now, that amounts to just over $15,000 for an individual, just under $32,000 for a family of four. Under the federal health reform law, federal dollars are going to pay for most of the costs of that expansion for the next few years.

Now, the option most of you know came about as a result of the Supreme Court ruling in June, that states couldn't be just given the choice of either expanding as the new law set out or losing all of the federal Medicaid money in the form of matching funds. That the court said was too coercive. So now we look to each individual state to decide whether to opt for insuring its residents under Medicaid up to 138-percent of the poverty line. Now, today we're going to look at the economics of those decisions. My guess is you're going to find it a bit more complicated a calculation than you might initially have thought. And so keep your eyes on the numbers.

We're pleased to have as a partner in today's program the Kaiser Family Foundation, the source for most of the best information about Medicaid end coverage in this country. And we're especially happy to have as co-moderator Diane Rowland, who's both the Executive Vice-President of the foundation and the Director of its commission on Medicaid and the uninsured. Diane?

DIANE ROWLAND, ScD: Thank you, Ed, and welcome everyone to another Alliance briefing on the topic of the Affordable Care Act and the issues with regards to its implementation. I think the last time we were together recently was about the Fiscal Cliff, but today we're looking at the other side of the Fiscal Cliff. We're looking at the implementation in many states of the Affordable Care Act and what that implication has for their cost, and especially for their coverage.

I think as we look at the numbers today and the impact, we have to weigh both what it means in terms of additional cost to the federal government, additional cost to the states, that it's largely supported by the federal government, but especially what it does to the uninsured population and the assistance that could be provided through this. I'm pleased that the study that the Urban Institute has prepared and will

be presenting here today will both look at the cost implications, but also at the coverage implications.

I know our panelists will get into discussing even further what that means on the ground and how states can take this information and hopefully add in their own ability to look more specifically at the offsets at the state level and the implications for the states to complement the work that Urban has done to look across all 50 states at the implications. So I think we have a great panel and a lot of useful information. So let's get to the information.

EDWARD F. HOWARD, JD: Terrific. Just a couple of logistical items for your checklist: You'll see on the slide behind me the Twitter hash tag. Did I say that right? So feel free to tweet and retweet as we go along. There are a lot of good pieces of information in your kits, including biographical information on most of our speakers anyway. You'll find their PowerPoint presentations as well.

There's a one-sheet, one-page sheet listed in your kits that has all the materials that are in your kit so that you could get at them electronically. All of them are available at our website at allhealth.org. There will be a webcast and a podcast available of this briefing on Monday thanks to our fellows at the Kaiser Family Foundation. You can get that

that, we will have a transcript to the briefing available for your perusal.

Green question cards in your packets; appreciate it if you'd fill them out and give them to us at the appropriate time. Somebody's already had a question sent forward, and there's a blue evaluation form that I hope you will use at the appropriate time to help guide us to improve these hearings and make them more useful to you. So as Diane said, we have a terrific panel. And we're going to start with an analyst who's taken a very close look at how states' bottom lines are going to be affected either way they choose to go on Medicaid expansion.

John Holahan directs the health policy center at the Urban Institute. He has decades of experience with Medicaid and state health issues. He is the main author of the new report, that you have the executive summary of in your packets, on the fiscal impact of the expansion decision by states. And if I pass him the clicker, he will be able to convey his information to you in the most effective way. John, thank you for being with us.

JOHN HOLAHAN: Thank you, Ed. I hope that's on. It looks like it is. So first of all, let me say that I had a tremendous amount of help from my coauthors, Matt Buettgens and

There’s an awful lot to think about. There’s a lot of pieces here, and it certainly couldn’t have been done without all the help that; there the four of us working pretty closely together.

The paper was a response to the Supreme Court decision that essentially made Medicaid an option for states. And as you know, a number of states have already said they are not going to do it. Others have said they are, and the decision was not to do it. It may not be permanent, but at least that’s where it stands right now. What this study did was to estimate the effect at the state level of the ACA expansion relative to no reform. And then we—essentially you have to divide it, because of the Supreme Court, into two parts. What would have happened? What would happen if there was no Medicaid expansion? And then what’s the implication of the Medicaid expansion itself, the states’ decision to go to 138-percent of poverty.

The first part is that just because of the Affordable Care Act, there will be increased Medicaid enrollment and increased spending by both state and federal government. Because of we’re setting up exchanges. There’s the no-wrong-door interface by which people will be diverted to Medicaid if they meet Medicaid’s income standards. There are various provisions for simplification. There’s outreach that’ll take

There's the individual mandate. That even though most of these people are not subject to, many will believe they are. As we know from the experience with Massachusetts, there will be increased enrollment among those who are currently eligible. In other words, the participation for those people will go up. So we look at both parts of that and look at the implications for federal and state Medicaid spending, state spending on uncompensated care, state spending relative to state budgets or state general fund expenditures, and then the impact on Medicaid enrollment and the number of uninsured.

A couple of things about methods: We have to develop a pre-ACA baseline for each state. So that's taking state data, growing it essentially by CBO projections out for the years between 2013 and 2022. Then we use our microsimulation model to estimate effects. The model has pre-reform eligibility rules for each state. So we estimate then with that.

What would be the impact on each state of if they didn't adopt it and then if they did? The participation rates are based on individual behavior, their consistent published literature. The cost per enrollee also varies with individual characteristics, the most important of which is health status. And between the participation rates and the cost per person, it's going to determine what overall costs will be. And just so

federal spending, which are all CBO releases there at 9/32 or at 9/52.

We have incorporated federal matching rates that reflect ACA provisions. That is the standard matching rate. So the current ones on any new enrollment among current eligibles, the higher ACA rates for new eligibles that go to 100-percent and phase down to 90, and then the higher match that's in the law for CHIP eligibles. We estimate savings to states that have limited benefit programs—an example is Maryland. That has a program that essentially covers ambulatory but not inpatient care.

States are allowed to drop those programs and those people who are served by them, for whom states are now paying at their current matching rates. They can drop those programs, and those people become new eligibles and get the higher federal match. And then there are seven waiver states that have covered children to adults up to 100-percent or so. And for them, they will get an enhanced match that grows from 50-percent on up to 90. We have two years' of data. The sample size can be a bit small. We don't think it's a big problem, but it's worth pointing out.

There are several sources of savings that we couldn't get at. And so I think our state costs are then going to be

option. So states could drop coverage say for I think the medically needy program. And those about 138 could go in and get coverage and exchanges. Those below could become new eligibles under Medicaid with the higher matching rates. Many services that are now provided by states, say mental health or substance abuse services could be covered benefits under Medicaid. For those who are newly eligible, we don't account for those savings.

And then there could be additional state revenues because of the increased federal expenditures in the state. And that could result in higher tax revenues. It could be premium taxes, and we don't get into that. Hopefully states can take what we have, build upon it, and develop and augment these results. Figure four is where we start. There, that pie has the baseline spending, state spending of about 2.7 trillion, the baseline federal spending of 3.7. The new spending because of the law if every state adopted the expansion would be 76 billion for states and 952 for the federal government, overall about a trillion dollar increase of this 10-year period.

Figure five breaks that apart. On the left-hand side is the same as in the previous slide, the 76 and 952. If no states adopt, states will then still spend 68 billion, with the federal government spending 152. This is largely increased

at the standard or the traditional federal matching rates. It will also reflect the higher CHIP match. If states adopt the expansion, then the aggregate costs at the national level would be eight billion, a federal spending of 800 billion.

The eight billion is a bit misleading because it has all of the savings, those enhanced matching states. And the big one is New York. So if you take New York out, where there's a savings of 33 billion, the cost to other states is 41. It's still, you know, a good deal for states, but it's not quite as good as that looks when you look at the national average. That's shown in this slide; where if you look at the US, we're looking at a 0.3-percent increase in state spending with a 21-percent increase in federal spending. That 0.3 is the same as the eight billion, and it is a national average.

In New England, the Middle Atlantic states which have a lot of these states that have limited benefit programs that can go away or enhanced match because of waiver programs. You can see that those states in that region on balance are savers. The big one that's driving this is New York, as I said before. If you look at to the right-hand side of that slide, there are large increases in percentage terms in federal spending; increases of about 3.5- to 4.5-percenton on states.

An example would be in the South Atlantic states. If

in new federal dollars. In the West South Central region, dominated largely by Texas, 8.5 billion in new state spending would bring in 102.4 billion in federal spending. The next slide shows this. In graphical terms, the states in black are those that come up with increased spending of four- to seven-percent. The states in white are those that are the net savers.

The next one is our effort net out the savings the states will have because of uncompensated cared. Again, on the left side is that 8.2 billion. We estimate savings to states, on less spending on uncompensated care of 18.3 billion. They spend money on indigent care programs now, payments to public hospitals and clinics, the state share of DSH payments. And all of that will go down. So the net spending at the national level will be a net negative of 10.1 billion. But again, that's a national average and so a bit misleading.

But you can see that New England and Middle Atlantic states will save the 4.6 and the 4.2 you saw before. That gets a little bit more—those savings increase a little bit more when you net out the savings on uncompensated care, but it's a small effect because those states already have a fair amount of coverage. It's a bigger factor, a bigger drop in net new spending by states when you look at the states that have the biggest coverage expansions. And they're beyond the right and

The next slide looks—so the previous slide, that 4-point-something-percent increase is relative to state baseline spending. I got to see if I have the right one up here. Yeah, is that one, around one? Yeah. So this is relative to state general funds. What is state spending now under their own budget? General fund spending is about 40- to 50-percent of all state spending.

So what this shows is the Middle Atlantic and New England states will save a little bit, so in a sense could give tax cuts or use the money for other purposes. The net new increases in the South, those that have the largest increases in coverage would see increases of a little bit more than one-percent. If you net out the savings on uncompensated care, that's a little less than one-percent. So relative to state budgets, the increase—due to the decision to expand coverage is not great. And what do you get for that?

The baseline Medicaid enrollment is 52.4 million. If you don't adopt Medicaid expansion, the amount that would come in for all the other provisions that I talked about would 5.7 million. With the Medicaid expansion you get another 15.6 or up to 21.3. That then has an impact on the uninsured, which start out in the baseline at 53.3. With the exchanges, the subsidies, the mandate, the Medicaid increases that would occur anyway,

If all states adopted the expansion, the reduction in the uninsured would go up to 25.3 or another 10 million. So it's important to realize that you only get the reduction in the uninsured by about half that we're used to think about if all states adopted the expansion. Otherwise it would be shorter, be less. This slide shows the increase by region. And to be quick about it, the biggest increases because of the Medicaid expansion are in states that have the largest coverage expansions than the three southern regions, which is not surprising. Most of the effects in the Middle Atlantic and New England regions are from the establishment of exchanges and increases in subsidies.

So to wrap this up: If all states implemented the expansion, the federal government is going to pay the vast majority of the new cost. And the gains in coverage are considerable, and they would substantially reduce the number of uninsured. Second bullet is saying that even if you do nothing, you will see more enrollment and more increase in both state and federal spending. The additional cost of implementing the expansion, which is probably the key point here, is small.

Relative to total state spending, that is the baseline; what they would have spent without the expansion. It's small relative to state budget expenditures. And it's small relative

decide to expand. The net savings to states get bigger if you account for the reductions in spending on uncompensated care. And then there are a whole lot of things that I mentioned at the beginning that we couldn't account for.

These are important for states to try to work out. Because there are so many states that are small net spenders, that if you account for these things, many of them could become small net savers. So I will stop with that. I apologize for going over.

EDWARD F. HOWARD, JD: Thanks, John; very dramatic graphics. Dan Crippen had a late-arising commitment with some of his governor members. So we're pleased to welcome back to our data, Krista Drobac, who's the Director of the Health Division at the NGA Center for Best Practices. Krista has served as a health policy advisor to a couple of US senators, to the governor of Illinois. She was a senior advisor at CMS, and she's here today on behalf of the nation's governors, who are shall we say less than unanimous in their position on this issue of Medicaid expansion. We're here to get the insights from you about that. Krista?

KRISTA DROBAC, MPP: So following on John's graphs, I'll try to give you the mindset of many state officials in thinking about Medicaid expansion. You know, each state started

and what Deborah Bachrach will talk about further, which is: Where are there savings and where are there more expenses with our expansion?

But I'm going to talk about—could I borrow that? I'm just going to try to give you sort of the mindset of what state officials are thinking right now. The factors are the state fiscal realities, the federal fiscal considerations. Then there are specific calculations related to Medicaid. And finally, what does this new population look like? And secondarily, how do we serve them?

So I think everybody's familiar with this kind of a graph. Obviously expenditures related to health care are crowding out other state expenditures. And governors have just come out of an extremely intense time period, where they had to find savings in all of their programs and really to a huge extent in Medicaid, even though there was a MOE. So it's coming at a time when it's very fresh in governors' minds how much Medicaid costs and how much it's crowding out their other expenditures.

And this graph just shows Medicaid costs relative to K-through-12 education, which has you know is a huge priority of governors, investing in education of their population. So when they think about these things, they're thinking about the

crowded out by increased Medicaid costs? I realized when I was on my way over here that I didn't need to have this slide because I'm speaking to a hill audience, but you know what the Fiscal Cliff is and the deficit reduction efforts next year, but it's weighing hugely in the minds of state officials.

When you look at the numbers that John presents and say to yourself it seems like a good deal, state officials say to themselves, well, what if we get wrapped up in the deficit reduction and they cost shift to states. So that 90-percent match in three years becomes 75. So if they commit now to expanding their populations, what happens if the FMAP gets cut or there are other cuts to Medicaid programs? And there has been a history of cost shifting to states, and so they legitimately worry about what happens in federal deficit reduction. And that factors into their expansion considerations.

So I just listed a few provider taxes, the blending rates, the FMAP, and of course block grants. So when they get down to the specific Medicaid questions, there is obviously a process, which again Deborah will talk about in terms of where do we—where can we save dollars in community mental health or things that are state-only dollars right now? But behind the really concrete dollars that they might save, there are

Could we expand to just 100-percent instead of 133? Could we expand over time? And if we do that, what does that do to our matching rates? Could we still get the 100-percent match if we decided not to expand for a couple of years? And then can we reduce eligibility after the expansions? So if we go up to 133 and then we hit some rough budget times, can we go back down to 100? So these, and then of course there's the DSH discussion. But I think every governor knows that the DSH reductions are in statute. So either way, there's going to be less money for disproportionate share spending. Then again, what will the future match rate be if a state expands later?

So there are questions about the flexibilities within the expansion. And then in estimating the impact, there's the woodwork effect or the welcome mat effect depending on how you think about it. But either way there's going to be a lot of people who sign up who were already eligible, and so they're not eligible for the enhanced match. So that's a consideration. How much is it going to cost us if we do nothing, which John's analysis captures well? And then, what are the current state-only programs that we could save money on? And what happens to our DSH payments?

So then of course there are the political considerations of what is the provider reaction, the provider

discussion is happening, and we haven't had a legislative session yet. Most state legislatures are in session next year, so there will be robust discussion in the state legislature about what to do about Medicaid expansion. And that's where the interest groups and the providers are really going to make their voices heard.

Again, the counties are the same way. The counties do take a larger portion of the uncompensated care costs. So they will also be talking to their legislators. And then from an executive branch perspective, what are the added administrative costs? How many more people do we need? How many more case workers? How do we process all these folks? And then obviously churn is another issue between the exchange and Medicaid. Can we encourage more people to go in the exchange given that 100- and 133-percent you're eligible for Medicaid and the exchange? So could we somehow encourage more people to go into the exchange? It's a consideration.

And then obviously, what does this new population look like? So you know when you get past all of the operational issues, how are we actually going to serve this population? I just put in—I think the new CBO number was 10 million was the assumption. This is what they look like. And then their care profiles are—I stole this slide by the way from the Center for

Health Care Strategies. You know, they have self-reported poor health. They've got pent up demand.

So I've seen some SAMSHA data that shows quite a high number. I think I saw 29-percent have behavioral health needs. So what—how does this population differ from our current Medicaid population? And how do we serve them well? I think that the agreement among many states is that there needs to be more primary care services to serve these patients. And how do you actually increase the number of care providers that you have if you do do an expansion? So I'm just going to end showing you a quick map.

Here is, and this is thanks to Kaiser, a map of the newly covered populations. I wish I could get a side-by-side, because this map actually goes with the next one. But if you look here, these are where there are going to be the most people, so in the dark areas. And then if you look at the supply of primary care providers, it's basically the mirror opposite. So how do you make sure that you're actually going to have people walking around with a card that gets them something?

So there is some discussion now around workforce implications. How do you actually increase the number of care providers for this new population. And then again, states are

pretty good response to this Center for Medicare and Medicaid Innovation state innovation models, grants. Lots of states were interested in applying for them and figuring out how can we change our system to improve care and reduce costs? So how does the Medicaid expansion population fit into this? And again, it goes back to how they look different form our current Medicaid population; with two minutes to spare.

EDWARD F. HOWARD, JD: How about that? Well, let me occupy a few seconds of that two minutes by clarifying something, Krista, if I can. You referred a couple of times to 133-percent of the federal poverty line. I said 138-percent of the poverty line. We've been having this discussion in our office. Can you clarify why we have different numbers?

KRISTA DROBAC, MPP: There's a five-percent disregard.

EDWARD F. HOWARD, JD: There you go; a standard federal calculation of what counts as income, right? With a five-percent disregard. So we are on the same—

KRISTA DROBAC, MPP: So Ed's right.

EDWARD F. HOWARD, JD: We are definitely on the same page. Thanks very much. Let me pass this in this direction if I can, because next step is Deborah Bachrach, who actually teaches courses on federal health reform law at NYU law school. She also advises states and others on the challenges presented

was the Medicaid Director for New York State, where she was responsible for the coverage and the care delivered of four million beneficiaries. So she knows whereof she speaks from a variety of points of view. And we're delighted to have Deborah with us today.

DEBORAH BACHRACH, JD: Thanks, Ed. Thanks, Diane. So what I've been doing is, I work with states to do the analysis, the fiscal analysis in their state. And when I go into a state, we have this very large table; because to do this right, we need the governor's office. We need the budget office. We need Medicaid officials and CHIP officials. And then we need the substance abuse officials, the mental health officials, long-term care.

So we have a large conference room, and we go through the slide deck that I'm about to present; but we have about four times as many slides as we try to dig into what's the fiscal implication. So the four factors we tend to look at, and they are really what went into John's analysis at a national level, we break it down at a state level. So we look at the cost of the newly eligible adults, the cost of the woodwork effect, and then we always say attributable to the Medicaid expansion. Because there will be a woodwork effect, but only a portion of that is attributable to the Medicaid expansion as

And then we look at where can the states save money when it expands coverage. And where does that expansion bring in new revenue? And then there's the econometrics model in terms of what are the flow of these new dollars coming into the state mean. So very quickly, the next few slides really just look at the template we use and the factors that go into calculating costs, so for the first is the cost of coverage for the newly eligible. And as you see, we look at the total number.

We look at take-up rates. A means-tested program you never get 100-percent take-up rate. So we look up take-up rates and ramp-up rates. Then the cost per member per year, and then the total cost in the state share. Then we do a similar calculation for the so-called woodwork or welcome-mat effect. I won't go through it. But it's really what John is doing on a national level; we do at a state level, with the state officials, with state numbers. Then we add the administrative costs. Most states do it as a percentage on their PMPM.

And we just note here that if you're using or if you've upgraded your eligibility system and it's ACA compliant, rather than getting your typical admin match which is 50-percent, you get a 75-percent match. And then we get to what I want to really focus on today, which is state and local savings and new

into them in more detail in the following slides, but where will the states save money through the expansion? And John alluded to some of them.

One is there are several Medicaid populations today that are covered with a regular match—50, 60, 70-percent match—that can move into this new adult group, which—let's just stop for a minute. The new adult group is in almost every state, all your childless adults, and a large number of parents. And so when they move from coverage today into that group in 2014, the state can take advantage of the enhanced matching rate. And we'll come back to that.

Now in some of these programs, they go above 133-percent of the federal poverty level. And the individuals above, who have now been funded with Medicaid with a regular match, will move into the exchange where there is no state fiscal contribution. Then— and we put this one here, which is the CHIP matching rate goes up in 2015 by 23 percentage points. Originally I didn't have these in my analyses. And the states are really counting this as money that's available to fund the expansion. Although you could press back and say rightly so that will come in regardless, but I will say that's how states look at it. So I've now put it here.

Then there are state-funded programs. John talked about

about those because that's a real source of savings. Because we have this patchwork of support for providers that turns into coverage in the future in an expansion state. And then there are the county- and city-funded programs. Then we get new revenue through provider assessments, assessments on pay or in general business taxes; again from the additional Medicaid revenue coming in.

Now, I want to pause with two slides here which really just give you the enhanced matching rate for the newly eligibles in my new adult group. The first slide is what we always talked about the: The 100-percent going to 90-percent by 2020. And that is the vast, vast majority of states. However, there are a handful of states, and New York, my home state, is one of them that are called expansion states. And an expansion state is a state that has already expanded coverage with a full benefit package to childless adults and to parents up to 100-percent. And in those expansion states, the enhanced matching rate is only for childless adults. And instead, and you'll see it in the chart in the right—instead of going down from 100-percent to 90, in an expansion state we go up to 90-percent.

Each year the state gets half the difference between its regular matching rate and what the so-called typical state would get. So we did it for a 50-percent state. So you do have

with the expansion because we've been paying for childless adults with a 50-percent match, and in the future it's a 90-percent match. But unlike many states, we will not get enhanced match for parents; only for the childless adults. But it is a buyout if you will for New York.

But there are many states in New York we would say, but that's still not fair because there are so many states that see that enhanced match for most of their parents as well. So here's the template we use to pick up the Medicaid savings. And on the left-hand side you'll see the programs that we tend to focus on where we can move populations from their current match into the new adult group with a full benchmark benefit and an enhanced match. The biggest one, it doesn't happen in every state, is many states have used waivers to expand Medicaid to subgroups to some. Colorado has its childless adults to 10-percent of the federal poverty level.

We have many states that cover the HIV population or cover childless adults and some additional parents, but with a very limited benefit package. John talked about one state that does it with no hospitalization. All of those folks are funded with a regular matching rate for the state, and they will move into our new adult group, be eligible for full benefits with the enhanced match. And we do the same analysis, breast and

Almost all states have taken advantage of this option. It's regular matching rate. It's for women, usually up to about 250-percent of the federal poverty level, who have a diagnosis of breast and cervical cancer. Those women who would not otherwise be eligible in the state but because of the diagnosis become eligible, with the availability of coverage through Medicaid and the exchange that program won't be necessary. And when it's eliminated, the individual will get a full benefit package not tied to breast and cervical, and the state will get an enhanced FMAP. Same approach with family planning waivers. We've already talked about CHIP.

Pregnant Women: The majority of states today cover pregnant women above 133-percent, usually typically to 185-percent; some states even higher. The question states are asking is should we maintain that program? Or should we bring it down to 133 because women with higher incomes can go into the exchange? There's a debate among states because many states think this is a program that should be continued in Medicaid because the child will ultimately be Medicaid eligible. And this is the best way to get coverage, but these are state opportunities for savings.

Then we do the same thing with state-only programs, and the biggest area is in mental health and substance abuse. In a

parents, their entire mental health and substance abuse system is funded through state-only dollars. I think one of the Michigan analyses found that that alone covered their 10-percent share. So I don't have enough time to go through all of these, but this is where it's a real state-by-state analysis.

Then we look at state revenue. Again, many states have assessments on providers, on health plans, general business taxes. Additional revenue brings in—additional Medicaid revenue brings in additional general fund revenue. Then we put it all together in the next slide. Then we put it all together and come up with a bottom line number.

So then we do the impact on the state economy, because we should at least mention that we're talking 20 million people are insured. We look at that for what it means in the population. We look at this in terms of what it means for jobs. And then my last slide, and I'm not going to do very much because I know Dr. Keeton is going to pick up here, is we stop and look at the costs of not expanding. So of course it means that individuals below 100-percent have no access to subsidized coverage in a non-expansion state.

I want to briefly mention employers, something that's gotten less attention. Because if individuals with incomes between 100- and 138-percent go into the exchange in a non-

go into the exchange and they get a subsidy because their employer is not offering affordable coverage, minimum essential coverage that's affordable, the employer will be subject to the penalty. And employer groups are aware of this. This is a new exposure for employers. Dr. Keeton will talk about what it means for providers with the DSH cuts.

So my last comment is system transformation. And Krista talked about that, but system transformation is more effective when everyone is covered; when the churning on and off of coverage goes down. So our ability to drive payment and delivery system reform I would suggest is enhanced in an all-coverage model in a state which expands Medicaid. So thank you very much, and I'm going to turn it I think back to Ed.

EDWARD F. HOWARD, JD: Terrific. Thanks very much, Deborah. And both Deborah and Krista mentioned the importance of providers in this equation. And so we are very pleased to hear finally from Dr. James Keeton, who's the Vice Chancellor for Health Affairs and Dean of the Medical School at the University of Mississippi. Ole Miss's Medical Center, excuse me, where the medical school is housed has a lot of the elements of a safety net institution. No surprise then what Mississippi decides on Medicaid expansion is going to have a profound impact on his operation.

Where, what is it? Twenty-percent of the state's residents are uninsured. That translates into a lot of uncompensated care I suspect. We're very pleased to have your perspective on this issue, Dr. Keeton.

JAMES E. KEETON, MD: Thank you, Ed. I need to make a few statements, and then you can chew on those the rest of your life. Health care is a right. That was established a long time ago I think on the Nixon Administration when they passed the EMTALA law said that we had to see people whether we wanted to or not. And we had to treat them. I happen to believe health care is a right whether that law is there or not. Health care is complex, or you wouldn't be in this room today.

The uninsured do not get the same care as the insured. We are in a two-tiered system. And our citizens don't want health care. They want health. Health care is ad hoc. We can put you back together after a car wreck, but what are citizens really want is health. So I would hope you'd think about those and think about them as we go forward in this process.

Now, I'm CEO of an academic medical center and Dean of school of medicine. We're the only one in Mississippi. There are 141 of these in America. And we play a huge part in the delivery of health care, even though we have three missions of health care, research, and training health care professionals.

University of Mississippi. And even though I went to Ole Miss, this is not the Ole Miss Medical School.

We serve every school. And our freshman class this year, we represent 38 different schools even though we only take Mississippians. So I have to be very careful because they all get funny about sports. Thank God I don't have a football team. Now, we have six schools, 2700 students on our campus representing just about every part of the health care science world. We have 9,100 employees, the second largest employer of Mississippi after the shipyards, and a $1.4 billion budget.

So let me tell you about me personally before I go into Medicaid. I'm a pediatric urologist. I practiced in just about every venue you can imagine. I spent a year in England, so I know the National Health Service. I was in the United States Navy during Vietnam for two years at a hospital. I understand how that socialized medicine system works. It works very well by the way. I spent time in the VA administration. They give good care to our veterans. I spent 20-something years in private practice, and now I've been 18 years in academic medicine.

I've seen just about every way you can deliver health care, and none of it is perfect. But we are trying. We are trying. And so I leave you with that for sure. Now, real

medical centers I think today. And the Association of American Medical Colleges, which is here today, would be unhappy with me if I didn't say something about students. We are the ones that are training the next providers that are going to live under everything you hear about today.

Now, these kids are smart. We have the largest number of people trying to get into medical schools that we've ever had in this economic time. And these kids are super smart. It's amazing how smart they are. And we are fully electronic now. I think they'd die if we went back to paper, but we're really proud of them. So every Monday, I meet with the leaders of the different classes, all four classes. So this Monday, knowing that I was coming up here, I said by the way. Tell me what you think about the Affordable Care Act. I don't call it the Obamacare. I said the Affordable Care Act.

And there were 10 of them there, and each one I made answer. Every single one of them was for it. Now, we are in the most conservative state in America. Every single student was for it. I got to the clinical ones, the M3s and M4s. I said why are you for it? And they said, well, Dr. Keeton. We see these patients in the emergency room with no health insurance. We've got to take care of them. It's the right thing to do. So I want you to know that they're out there, and they care about it. So

we see 14-percent uninsured. That's seven million negative each percent to our bottom line.

So I go talk to civic groups. I say to the civic groups, how would you like to run a company where you give away 14-percent of your business? Fourteen-percent of the cars are gone the moment you open your door. I hadn't thought of it like that? I said yes sir. That's what we do because we have to do it by law, and it's the right thing to do. We see 100,000 in our emergency room a year: 30,000 children and 70,000 adults. Seventeen thousand adults don't need to be there. They're there because they don't have a medical home.

Now, we've combined with our health department and the FQHC, Federal Qualified Health Centers, to find a medical home for our patients. We're trying to do this even before the Affordable Care Act. So most of you know of this guy; pretty famous, from Oxford, Mississippi. He was still living when I was at Ole Miss, but I was too scared to go up and speak to a Nobel Prize winner. But this is what he said: To understand the world, you must first understand a place like Mississippi. Now, I paraphrase that now. To understand Medicaid, you have to understand a place like Mississippi. I think he would allow me to do that.

So here are the hard facts. They're scary facts, but we

million people, 23-percent on Medicaid and 20-percent uninsured. Folks, that's 43-percent in poverty in our state. The majority of them are in the 18 counties of what we call the Mississippi Delta. And look what we lead in. I'm embarrassed to show it to you, but it's true. It's opportunities we call it. We don't call it problems. We call it opportunities. We lead in poverty. We lead in obesity. We lead in teen pregnancy, infant mortality, and traffic fatalities. We're the last in the nation in physicians per capita, but we're the fifth best in America of retaining our graduates in Mississippi.

So we're doing some things right, but we have to correct that 43-percent. Now, currently we have almost 700,000 on Medicaid. Our new enrollees if we expand Medicaid are 300,000. A third of Mississippians will be on Medicaid if we expand Medicaid. Now, we take that 310,000. Our cost will be an extra 159 million. We're spending 973 million on Medicaid now. You add the 159. Then you figure in the economic impact of that extra money. The bottom line to us in 2025 is 96 million extra a year for covering these patients and these people. All Mississippians participate.

We get DSH payments in Mississippi of 210. DSH payments, remember, a disproportionate share. And the University of Mississippi Medical Center gets 69 million of

payments, I will change programs, ground helicopters, and do everything that might possibly happen. And that is scary to me. That is the perfect storm that we are very nervous about. Don't expand Medicaid, and DSH payments go away. Now, we're not sure whether HHS is going to use that as a stick or if they can do that.

I hope that's some conversation we have today, but let me tell you the good news. I can pick up the phone today and I can call Governor Bryant and say Governor, I need to talk to you about help, and he calls me back. We may be on different poles of where we are, but we both want to do something about our citizens. And the other thing is under Governor Barber, prior to Bryant, we put in the Health Care Exchange. If you look at that, we're the only state down there in the Deep South that put in a health care exchange because we believe it will work, and we want to do it.

Now, isn't it funny that we haven't mentioned one other thing; that we might improve the health of people and what that will do? Everyone one of you has got college graduates, and most of you are graduates of above that. The longer you stay in school, the longer you live. If you stay in school in ninth grade, you live longer than sixth grade. So if you're educated, you live longer.

So I am tied to education. And to close that triangle, that means jobs. So it's a simple thing I say to Governor. You get them healthy, you get them educated, and we can help you get a job. And they understand that. Somehow we have got Washington and the states to balance it out and have the ability to do what I am able to do in Mississippi is call legislators and call the governor and work through this problem. And we're going to try to do it.

This is a fascinating time. Having graduated med school in '65 when the Medicare and Medicaid came in, what I have seen and what I have ever believed in my life at 72 years of age, I'd be sitting here talking to you about Medicaid expansion. I wouldn't have. But I am happy to say that health care is finally on the table and that we're going to do something about it. So it's a pleasure to be with you today. Thank you.

EDWARD F. HOWARD, JD: Thanks very much, Dr. Keeton. By the way, Diane mentioned also the human dimension of this. In the back of the packets on the right-hand side is a brand new Kaiser publication called "Faces of the Medicaid Expansion." And if you have a chance to take a look at it, I think you'll be very moved by some of the stories that are chronicled there. Now is your chance to either write a question on a green card and hold it up and have it brought forward or go to one of the

If you do the latter, we'd ask you to be concise to identify yourself and to direct the question if you want a particular panelist to respond. Diane, you've got a question in waiting. Or do we have someone up already? Yes? Go ahead. We'll start there.

AL GUIDA: Yes, hi. My name's Al Guida. I'm with Guide Consulting Services. I represent community mental health centers and other mental health clients. This is a question for Deborah and John, but I want to clarify a point that Krista brought up during her presentation. The Substance Abuse and Mental Health Services Administration has estimated that upwards of 10 million people in the expansion, both Medicaid and the state exchange, will be individuals with a mental illness, an addiction disorder, or both. It's about one in three people more or less in the exchange.

There's an unpublished study I've seen which puts the figure at 13 million people. So I have a particular question for Deborah and John about your enrollment assumptions that underlie your work. What's little known about these conditions is that there's a high incidence of cognitive disabilities associated with them, and so we as providers struggle to get these folks enrolled.

There is a study put out by the National Association of

indicates that a very significant portion of the residual uninsured population is people with mental health and addiction disorders. Because again, we struggle to navigate the enrollment processes to take advantage of this coverage and actually get people insured. If you could just sort of talk to me about that just a little bit, that would be very helpful to us. Thank you. I will sit down and take your response.

JOHN HOLAHAN: Okay. We try to as best we can use the published research literature, which has tried to estimate participation rate models to take into account all kinds of health characteristics of people as well as income, education, other characteristics to estimate take-up rates. And we rely on that. And you know by and large, people in poorer health are more likely to sign up. There could be pockets of them with mental disabilities that don't. You know, offhand I don't recall how we do that.

But I think—I just want to make one other point, because it came up before, is that by an large the population of these childless adults who are going to come into Medicaid is going to be considerably healthier than the population that—not just the SSI population; the people who are already being served. That's going to maintain a population. They're a population that has a lot of those kinds of people too. When we

distribution that is pretty sick, but by and large they are quite a bit healthier than the Medicaid population.

And so what it means is that when you open up the program, you're probably going to get—more likely to get the sicker end of that distribution, which could drive up costs. But as the program expands, you get closer to 60-, 70-, 80-percent participation. You're going to get a population that's going to be less costly, and on balance more healthy than the population we're already serving.

DEBORAH BACHRACH, JD: So if I can follow up on that, this is an issue that comes up in a lot of my meetings. And it starts out with a discussion about the outreach that the providers can do and the state can assist on. And in fact, the Affordable Care Act has specific language about outreach to vulnerable populations. So you're right. We have to get all vulnerable populations. There's an outreach process.

The good news is then once we are able to enroll vulnerable populations, there's a passive renewal process, an administrative renewal process. That it's far simpler than what exists, which helps us keep people covered. So I think that's a big piece. The other piece that's important to remember; this is new for Medicaid. For the expansion population, they receive what in statute is called benchmark coverage. Mental health

moving people out of a fragmented system, I can see you're nodding, and into full coverage.

And then the last point I think is even when states talk about being able to ratchet down their state-only mental health spending, which they do and which they expect to, it's not on you know January 2, 2014. But it's over time as individuals do come into coverage. So, all of the incentives and the infrastructure support the enrollment and the maintenance in coverage of vulnerable populations.

I think one thing is we need our community mental health facilities to learn how to bill. I mean there's a whole other issue, right? I know you're nodding too. That that comes along with moving from essentially a grant program to being a provider in an insurance system. So I think that's—I could keep going, but I'll stop. Thank you.

NASIM MEMON: Good afternoon; Nasim Memon from George Washington University School of Public Health, Health Policy Department. My question is geared to Dr. Keeton and to Krista from the Governors Association. Dr. Keeton, you mention at the end that the different options that you're going to try to work with the governor. Can you please expound on more, because it's imperative for the uninsured.

I know you have a high percentile of people that are

is Mississippi addressing? And then Krista, can you please address this question for Texas, South Carolina, Georgia, and Florida, which are the other five red states that are opposing Medicaid expansion?

JAMES E. KEETON, MD: So what we think is going to happen to Mississippi is soon as the small hospitals go to their senators and representatives, whatever party they're in, they're going to call and say, my goodness. DSH payments are going to go down and we're going to be in the red, and we're the largest employer in this town of 20,000. We don't want that to happen. And then the calls will be coming in in January, February, and March when we go into legislative session. And that's when the rubber will hit the road and people will start making their decisions about what to do.

Other options right now, I'm not going to put those out because I'm not sure there are a lot of other options. Only option for the state of Mississippi if you don't expand Medicaid is you're going to have to come up with DSH payments. If the federal doesn't come up, the states are going to have to come up with it.

KRISTA DROBAC, MPP: So governors are submitting their budgets right now to the legislatures. And those are due starting now between November and March. And so you're going

annual budget addresses, because that's where you're going to find out what their assumptions are about what they plan to do for the remaining population that's uncovered.

RON W. MANDERSCHEID, PhD: I'm Ron Manderscheid from the County Behavioral Health Directors. A question, comment: No one mentioned benefit structures here. It seems to me that's a critical factor in the design of the Medicaid expansion, the issue of having an even table between the affordable insurance exchange and the Medicaid expansion to not create incentives one way or the other and so on. I'm curious why no one mentioned benefit structures or the essential health benefit.

DEBORAH BACHRACH, JD: Well in Medicaid, benefit structure is very much under consideration because the statute says that new adults receive a benchmark benefit which must include all the essential health benefits and must meet mental health parity. And most states are looking at their current benefit package and seeing how does it meet that standard, how do we want to change it, and what are the needs of the population? So I referenced it, but I think it's very much on the table. I think that the benefit package for the new adults will be a very robust benefit package.

In fact, just two weeks ago CMS clarified that medically frail individuals within that new adult category must

Medicaid, the benefit package will meet the needs of the new adults. Do you want to talk? I can go further and talk about essential health benefits. But Krista, why don't you pick up?

KRISTA DROBAC, MPP: I just wanted to add two things. One is it comes up a lot in the context of behavioral health, which again as Al discussed and we've discussed up here, there are a lot of newly covered populations that have behavioral health needs. And there isn't as robust behavioral health benefits in the private sector. So if you choose a small group plan, you may not be able to serve the needs of the population that's currently getting benefits from state only programs. So that's one area.

And then another is, you know a lot of the benefit package comes down to how will people behave if you add more benefits or less? So you know, are more people going to spend down and be on traditional Medicaid, which gets a lower FMAP rate, than if they stay in the newly covered population? So a lot of the benefit package calculations go into—well, which category of federal match do they fall in? Unfortunately, that's just—you know, it has to be a calculation related to the budget.

FEMALE SPEAKER: A question for John with regard to the current spending on uncompensated care that you accounted for

in your study: Is that state specific? Or how did you do the uncompensated care relation?

JOHN HOLAHAN: Well, the numbers that I had in the slide are the state's savings. Essentially you know, you start in the baseline with an uninsured population. They receive a certain amount of uncompensated care. You reduce he uninsured, so uncompensated care burdens go down. There has been work on who pays for uncompensated care, and it turns out that states and localities including counties pay for 30-percent of it through various mechanisms. A lot of that is hard to disentangle and get rid of, although you could get rid of a lot of it.

So we only assume that states would be 33-percent successful in reducing spending on their share of that burden. So you know, I earlier this week talked to a Medicaid director who said that we were way too conservative; that you could get a lot more and have them as savings. So it's I think a conservative assumption, but that's more or less how we did it.

FEMALE SPEAKER: And probably a good example of John's work being taken down to the level with Deborah of really getting specific state data, because the states obviously know a little more about what's going on the ground than national data will pick up. Dr. Keeton, there's two areas here where I

The first one is on any of the strategies that you're using at Mississippi Medical Center that could be applied toward national delivery system reform. Sort of what are you doing on the ground? And the second related one is they also want to know whether the ACA is likely to draw down income levels of health care providers. Is it going to help their income or hurt it?

JAMES E. KEETON, MD: Well, what we did—I mentioned very briefly prior to the ACA and everything is that the Community Health Center's FQHC, Federal Qualified Health Center; the original one was in Mississippi in 1964 in the Delta at Mt. Bayou. So they've been in our state a long time. There are 23 of them. Most physicians and hospitals didn't know what they were doing.

We decided we knew what they were doing, and we better be a partner. So we took our state health department and all 23 FQHCs and joined them together with us under what we call Healthy Linkage. And we now in our emergency room for instance, we ask the patients do you have a family doctor or a doctor? And if they say no, we get their zip code. And we can get them a direct appointment in the FQHCs. They deliver really good health care.

Michelle Obama got beat up a bit about that in Chicago,

they give great care. In fact, they run some of our clinics for us. They are building a clinic right next door to us. We have to use that venue. That is a wonderful venue of centers that we can get medical homes pretty quick for patients, because there is.

To answer the second question, what we're doing at the teaching level is that we're teaching in teams now. We cannot produce enough physicians in America to take care of everybody in the traditional way. We have to do it with teams, extenders, nurse practitioners, that sort of thing, pharmacists, social workers, you name it; pharmacists, big time player at our place. So we have to teach a different way and we're going to have to deliver health care a different way, but there are ways to find medical homes for patients.

We are worried that a lot of our physicians do not take Medicaid, mainly in the metropolitan areas of Jackson and the Gulf Coast and Tupelo, where they don't have to. So they don't want to because it doesn't pay well, but we think that we can get them provided under this team method. We are doing lots of telehealth; that'd be the third thing I would say to you, particular into the health. Telepsychiatry, tele-emergency rooms, tele-ICUs; you name it, we'll do it. Teledermatology. So there are multiple ways we're trying to get health care to the

FEMALE SPEAKER: In terms of your work, Deborah, there was a question about how states are considering the CHIP FMAP increase. Could you explain a little more about what that is and why they want to figure that into the calculation?

DEBORAH BACHRACH, JD: In October of 2015, under the Affordable Care Act the CHIP match, which is now 15-percent higher than the Medicaid match goes up by 23 percentage points. So that means the state savings because you'll be replacing state dollars with federal dollars. And when states are looking at the cost of the expansion and the savings, how will they pay? The savings and the new revenues; how do you pay for the 10-percent that comes in, you know, in 2020?

So that's the issue. They use it as a way to fund the cost of the expansion to the extent it isn't funded otherwise when they're looking at a full budget. I know when I said it, some of you nodded. Yes, it will happen anyway, whether you expand or not. But it is within the population of low-income children and adults and then becomes an opportunity to use the dollars that had been spent on CHIP to fund the expansion of Medicaid for low-income adults.

FEMALE SPEAKER: Thank you. This question goes back to the issue that Krista touched on a bit, but what is the effect of the timing of these decisions? When will states actually be

have to happen? And what are some of the factors or pressures that might tip a state to go one way or the other as they look at the kind of calculations that Deborah and John have put on the table?

KRISTA DROBAC, MPP: So the calculations started back in, you know, the summer; in July really. We had a meeting post-Supreme Court and states were already talking about the different factors that go into estimating the impact. So it's been going on for quite some time, but CMS gave states a lot of leeway in making their decisions known. They don't really have to declare. But again, I think you'll see it reflected in the state budgets that are submitted over the next few months, and then a robust debate in the legislature. So I think it will be a much clearer picture around June of next year when most legislatures have adjourned. So I think it will be much clearer then.

FEMALE SPEAKER: Diane, if I could just add one thing to that. I agree with what Krista said. I think we'll see it in the first six months of '13 as part of legislative sessions and building budgets that often go into '14. I do think that while CMS is not putting pressure on states, the fact is the ACA is quite clear that the 100-percent FMAP is for three years. It's not for enrolling three years. It's for '14, '15, and '16. I

So if they delay the expansion, they lose one year or six months of the 100-percent. And New Mexico had an early expansion. And it's interesting because they've been at many meetings with them. And they've said that when we talk about the pent up demand that Krista referred to, they saw in the first few years but then it evened out, all of which has states saying do I want to give up one year of the 100-percent match? I mean obviously there are other considerations, but that is a pressure point for states. Wait, John.

JOHN HOLAHAN: Could I just add? There's one thing about what states do, and you're one, but that could really change. As there is an awful lot of federal money the states will be forgoing, that is money that would go to hospitals and various other providers. And it's just hard for me to imagine that the states cannot adopt this expansion after a certain period of time. Because I think there'll be pressure from hospitals, business community; just a lot of people saying why are we giving up all this money while our tax payers are paying federal taxes which are really going out to people in other states?

The economics of it are just so overwhelming that I think it'll dominate the politics. And whether it does and you're one, I suspect it won't. But I mean I think eventually

DIANE ROWLAND, ScD: So I just want to reinsert the concerns about what the federal government is going to do with their budget again into this. Because the timing of that is also really key. Because if we see a deficit reduction deal you know early next year, and it has significant cuts to Medicaid, that too will affect decisions. Because again, states feel a lot of anxiety about making a decision to expand a program, and then having the federal government change the rules and shift more cost onto the states. And then they have more people with less money, and it just becomes a spiral. So don't forget about your role here.

FEMALE SPEAKER: Well, in fact there's a question right here that says what are your biggest budget concerns regarding the possibilities for Medicaid changes in the context of deficit reduction? And are there any Medicaid savings options that would be acceptable or workable in the context of deficit reduction, which was not the purpose of this discussion but obviously it does relate very closely to the decision-making process?

FEMALE SPEAKER: I think states would like smart consideration of what could save money in Medicaid rather than a lot of the around the edges stuff that we've done in the past. And you know, provider taxes, blending FMAP; those sorts

actually change the trajectory of cost increases in health care. So Medicaid is a reflection of the rest of the health care system of cost going up.

So I think that rather—I think the hope is that rather than sort of figuring out the sort of around the edges solutions, are there some things that could actually change incentives in the program, delivery system reform, and things like that rather than just straight, you know somebody's got to get cut? And there will be other ways that costs will go up if we simply change the formulas.

EDWARD F. HOWARD, JD: I know some of you have to leave before we are going to be finished. If you do, I would be very much appreciative if you would take to time to fill out your evaluation form before you go. I wonder if I could sort of follow on this line of question with one further request. I don't know whether Krista or one of the other panelists would be interested in taking it on. Are there pieces of guidance that states are waiting for from CMS to be able to make these decisions with a little more clarity? And if so, what are they, and when do you think you might get them?

FEMALE SPEAKER: Well, Medicaid benchmark was a big one, but that's been helpful. But I think one of the questions is, is there flexibility within the expansion number? So can a

Can they? Is there flexibility within that? That I think would be really helpful because then states could potentially gradually move up rather than going all at once. I think there are others, and we sent several letters I think to the secretary, which are on our website, that delineate all of the guidance that we would love to see. John?

JOHN HOLAHAN: Well, actually I'm going to toss it back to you and Deborah. I mean isn't that in the law? I mean is that something that HHS can even?

FEMALE SPEAKER: Well, this is sort of the question of the day, right? So the question is can a state expand to something under 138-percent. I think the answer, I hesitate. Thank you, John, for throwing this at me. But I think it will be very hard for CMS to authorize a state to do anything but 138-percent. I think it is an all-or-nothing proposition. And the reason I think that is because the new adult group, it's a section-eight group. It is added to the list of mandatory populations. Children are mandatory populations; pregnant women. There are certain mandatory populations, and new adults are a mandatory population.

The Supreme Court decision did not change that. All the Supreme Court decision did was to say that if a state does not expand to 138, does not do the expansion for the new adults, it

court did. So that I think legally the better read is, it's 138-percent of the federal poverty level.

I would also remind you, and I should—you know, you all know better than I do that there was a lot of discussion in Congress about whether Medicaid should go to only 100-percent or 133-percent. And as I understand it, one of the reasons you choose 133-percent, because it was less expensive for the federal government that going to 100-percent. So there's both legislative history, but there's also the statutory interpretation that I think will prevent CMS from concluding that states can go to something under 138.

FEMALE SPEAKER: Well, this question actually falls in the same category. We've talked a lot about some of the costs that a state elects not to implement the full expansion would still incur for the eligible but not yet enrolled. And so the question here is, but would there still be a maintenance of effort requirement? Or couldn't the states cut back on some of their eligibility in the absence of that? And then the second question is what really happens to the people who are below 100-percent of poverty and ineligible for the exchange subsidies or coverage if a state chooses not to expand?

FEMALE SPEAKER: CMS has clarified that you can reduce eligibility after 2014. So if you go to 133, you can go back

governor's budget assumptions for what their plans are for the people under 100-percent of poverty. I mean at this point if they don't expand—it seems like status quo, but we'll have to see what the governors are planning for it.

FEMALE SPEAKER: Here's just a comment on the reduction in eligibility. Though you can't reduce eligibility totally, so the mandatory groups are still there and the TANF levels for adults. In many of the states where the largest number of people would be coming onto the rolls in the South for the expansion are the states with today the most meager levels of eligibility for adults; so that there's probably not a lot of room to cut eligibility in those states. So the woodwork effect might be stronger in those states than in other states.

JOHN HOLAHAN: Not in those states, but in principle other states could reduce their adult populations below 100. I mean I think those that have done that are probably unlikely to be the ones that would take advantage of that.

JAMES E. KEETON, MD: We're estimating that 100,000 people are coming in under the woodwork effect. I didn't put that in these numbers, and that'll cost another 100 and something million a year added to the numbers I showed you. So that's a group we just don't have a good handle on. Can I ask the panel a real quick question since it impacts Mississippi?

Do you think that DSH can go away even if a state does not expand it? Can HHS do that?

FEMALE SPEAKER: Yes, Deborah.

DEBORAH BACHRACH, JD: The Affordable Care Act cuts federal DSH payments. So we're only talking about the federal share. Remember, there's always the state. So it's been 11 billion in federal dollars. By 2018, it's cut in half. And the language of the ACA, and somebody said that, it gives the Secretary the discretion as to how to allocate the cut. And it gives factors you should consider. And one of the factors to consider is the number of uninsured in the state, and it is simply one factor.

So as we were talking about, I feel fairly confident that a state that doesn't expand is going to see a significant DSH cut. I can't tell if it's going to be 50-percent, 40-percent, or 60-percent, but it will be a significant DSH cut. And the Secretary has no discretion but to cut it. There's wiggle room as to how she cuts it, but there's no question she has to cut it. I think we will see guidance on this, dare I say the first quarter of 2013, which will drive that home.

FEMALE SPEAKER: So as the final question, we have sort of as all of these numbers, the cost, the numbers of people who could be covered who would be left uncovered are played out.

stakeholders involved in this decision? We hear a lot about the governors will decide, but what pressures do we expect to happen at the state level that might sway this in one way or another?

FEMALE SPEAKER: Well, it's the hospitals. You know, I was nearly state's Medicaid Director, and I couldn't get anything through without the support of the hospitals in New York State: The hospitals, the nursing homes, and to some extent the physicians. So the health care provider community will be an absolutely critical stakeholder along with consumers. And remember, almost every—and Dr. Keeton said this, most elected officials have at least one hospital in their district, and it is always the largest or second largest employer.

JAMES E. KEETON, MD: Mississippi Hospital Association has come out for expansion of Medicaid, so it's started. It's just a matter of what's going to happen behind the scenes.

JOHN HOLAHAN: In our report we have a table in it that shows the increase in revenues to hospitals if you adopt the expansion, and the number is 314 billion. So that is far greater than the loss of the, I think roughly, 56 billion in DSH payments. So again, that's another strong incentive to adopt the expansion.

FEMALE SPEAKER: I would just add counties to the list as well. They're going to be—the counties definitely have a lot of responsibility for the uncompensated care. So they'll also be advocating in the legislatures.

JAMES E. KEETON, MD: I had one last thing for the question that was asked to me about what's going to happen. I—the non-profit systems have been pushing lots of patients, particularly academic medical centers. Lots of them are faith based. I find that most interesting. But I think the IRS is going to come into play somewhere and say to nonprofits, you're going to have to do your fair share. Right now across the board, that is not exactly what's happening. So that'll be one little side effect of what's going to effect the delivery of health care and who's going to take care of these patients.

DIANE ROWLAND, ScD: And we're all going to be watching the deficit reduction discussions. Maybe at some point the nation will decide how to move forward on really restraining overall health care spending so that some of these programs can be put in place and people can get not only health care coverage but better health at the end of the day.

EDWARD F. HOWARD, JD: I couldn't think of a better word to end on except to note that that's why I feel better about Medicaid. Knowing that Dr. Rowland is not only occupying

oversees the Medicaid and CHIP programs in the same way as MedPAC does for Medicare on behalf of congress. So we're looking forward to great things from all of the people up here except me. Take one more crack at filling out the blue evaluation form if you will.

Thanks to the Kaiser Family Foundation and its Commission on Medicaid and the Uninsured for helping us put this program together. Thanks to Deborah Bachrach for suggesting it a couple of months ago. Thanks to you for turning out in record numbers at a not very convenient time. I ask you to join me in thanking the panel for a very illuminating discussion.

[END RECORDING]