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Briefing: Healthcare in the 2006 Budget: What's Next? What to Watch for in the Coming Debates?

February 18, 2005

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ED HOWARD: . . .relationship between healthcare and the new budget. On behalf of our new chairman, Ray—What's his name? Jay Rockefeller! Ray Jockefeller [laughter]!—and our vice-chairman Bill Frist and the rest of the board. Healthcare may not be being described these weeks as a crisis like some other topics, but you can count the state components of programs like Medicaid and the tax expenditures that are linked to healthcare. We're talking about a trillion dollars or so, and as Everett Dirkson might have said today, "a trillion here and a trillion there, and pretty soon, you're talking about real money." So our goal today is to allow you to kind of step back, get some perspective on the healthcare budget issues large and small, and with the help of some of the most insightful observers around, write that second round of stories that you're planning.

Our partner today is the Robert Wood Johnson Foundation, the largest philanthropy in the country with an interest in health and healthcare, devoted exclusively to it, as a matter of fact. We're happy to have Stuart Schear, the Senior Communications Officer at RWJ with us this morning. He's no stranger to Washington, either, I might add. Stuart, if you'd like to say a few words?

STUART SCHEAR: Good morning, everyone, and thanks to Ed and The Alliance and all the speakers for participating in

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today's discussion. I just want to say a few words about the Robert Wood Johnson Foundation. For the record, we're the largest healthcare philanthropy that's dedicated to improving health and healthcare in the United States. There is another foundation in Seattle, the Gates Foundation is a little bit larger than we are, and of course, they have a tremendous interest in global health issues. The Robert Wood Johnson Foundation is located in Princeton, New Jersey. Our assets are roughly $8.5 billion. We spend about $450 million a year on a wide variety of projects to improve health and healthcare in America. Some of the key issues that we are concerned about, are of course, involved in the discussion today, healthcare coverage for all Americans, quality of healthcare, improvement for quality of chronic illness, issues related to combatting obesity and the ill effects of substance abuse and alcohol, and of course, tobacco use. Part of our grant making is focused on working with journalists and supporting journalists. There are a lot of things that we think are important to a healthy policy debate in a democratic society, and one is excellent journalism. For that reason we sponsor six briefings a year with the Alliance for Health Reform as well as its online resource guide for healthcare reporters. It also provides support for the health programming on National Public Radio, as well as local public radio stations through the Sound Partners Project, a number of special programs on PBS, and we'll soon be

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announcing a new news partnership as well. We also have just begun to support the National Association of Healthcare Journalists in a number of different ways, and we're delighted to be doing so. As I noted, we really do believe that a strong analysis by journalists of the current healthcare debate is extremely important to a healthy healthcare discussion. We thank you for the work you do and we're happy to be supportive of it. Thank you.

ED HOWARD: Thank you. Thanks very much Stuart. And by the way, Stuart is sort of the world's foremost authority on Cover the Uninsured Week, which is coming up in May this year, and if you have questions about that as it goes in its many manifestations, I'm sure he'd be delighted to help address them. We have, as Stuart noted, some really great folks to help us with this discussion. A couple of logistical notes before we do that—there will be a webcast of this event available at kaisernetwork.org as of the close of business today, and a transcript probably by Tuesday or Wednesday of next week, both on their website and ours at allhealth.org. I'm going to do very brief presentations by our speakers, leaving you the maximum time for questions and answers. I'm going to introduce the whole panel at once to get rid of any discontinuity that might otherwise occur and I apologize to the speakers for not doing them justice. There's a lot more

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information about their backgrounds in their packets that you can use for contact information. So, let's get at it.

John McManus, who is either on my far right or your far left, depending on how you look at it, is the former Staff Director of the Ways and Means Health sub-committee, where was the key health advisor to the committee chair, Nancy Johnson and the Ways and Means Committee Chairman, Bill Thomas. His responsibilities in that capacity included, among other things, the Medicare Modernization Act, which some of you have chronicled in its implementation and its legislative journey to enactment. He also had a big role in the Trade Act tax credits that were groundbreaking in their bipartisan support for a new way of financing health insurance for a number of folks. He's now CEO of the McManus Group, which is a policy and political advice-giving firm, for healthcare and tax clients. John, thanks for coming.

Cindy Mann is a research professor at Georgetown. She's one of the top experts on Medicaid and S-Chip in the country. For a couple years at the end of the Clinton Administration, she had responsibility at what is now CMS for the Children's Health Insurance Program and the family and kids aspects of the Medicaid program as well. Before that she headed the center and Budget and policies priorities health policy.

Gail Wolensky, one of the country's most respected health policy analysts. Both sides of the aisle ask her for her advice, and she's been very generous in giving it. She's a former advisor to the first President Bush. In his administration she ran the Medicare and Medicaid programs. She's now a Senior Fellow at Project Hope. Yesterday she was a featured witness at the House Budget Committee's examination of Healthcare and the '06 Budget, so she'll share some of that insight with us today.

Ray Schuppach is in his second decade as the Executive Director of the National Governor's Association. He's well known around this town as a thoughtful and balanced policy person. Probably less well known is that like Gail, he holds a Ph.D. in Economics. He spent seven years at CBO, including a stint as Deputy Director, so he is no stranger to both ends of this debate, either.

So, I can't imagine a better mix of insights and views and experiences, and we'll start with John. Then we'll get to your questions. John?

JOHN McMANUS: Good morning, and thank you for having me here. I've tried to stay under the radar screen since my departure from the Hill, so I haven't seen a lot of you guys recently. As you may know, I was forced out of that job after not seeing my family or wife for more than a year, with 12 to 18-hour days and then my wife gave birth to my second child

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while the Senate was voting on the [inaudible] and I wasn't sure I was sure. I was getting frantic e-mails from my colleagues saying they weren't sure it was going to make it, so of course I'm in the delivery room with C-SPAN on, to see if my baby would make it. Of course, we did, and I'm able to survive my first year in business in the private sector. But just on that note, [inaudible] just on my own personal observations as a personal staffer, not on behalf of any clients or anyone else.

I think when you look at the healthcare budget this year, there's two big themes that I would note, and the context is, Number One, the Bush Administration and the Republican leadership want to successfully implement the Medicare legislation that passed a year and a half a go. I think they rightfully realize that will define the Bush legacy on healthcare, and so, when we saw the President's budget, there wasn't a whole lot on Medicare. I think that's because they're focused, appropriately, on making sure that the major reforms and the new benefits and improvements to Medicare can be successfully implemented without any problems.

Secondly is the realization that we have significant budget deficits, and healthcare is part of that. I think in that context, we can see what's being proposed and how Congress is receiving it.

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I guess there was a big news last week when we saw the new budget window—It wasn't any shock to those of us who actually follow these things—when you take two empty years away when you don't have a drug benefit, '04 and '05, and add the two expensive years, you would have a much different score. I think what some people forget is that last year's discussion about the budget estimates were completely focused on CBO's estimate, that 395, verus CMS at 535. What we didn't focus on was the '04 estimate, and so when we had this year's estimates come out, we didn't just get hit by the two empty years and two large years, we also had a two-year change, not just a one-year change. I think that if we look at the CMS estimate last year, it actually would have been 600, so you'd have a 500 to 600 to 700, rather than jumping from 500 to 700, and CBO is still about a third lower than that, and they really haven't changed. When you look at the overall estimates, they really, down the line have not changed more than about one percent or so.

Notwithstanding that, I think the members are concerned and a lot of Republicans in the caucus are concerned about entitlement spending and they want to do something about that. And Medicaid as well. So when you consider that, in looking at the budget structure, 50 percent of it goes to Social Security defense or interest on the debt, and Medicaid and Medicare together represent about 20 percent of the budget, and over the next decade will increase to about 26 percent, they're

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probably going to be part of the solution if there's a real goal toward deficit reduction.

I think also, one thing that the Administration and Congress is grappling with when you're looking at the Medicare part of that is that it's very difficult to put a package together when you consider the top three spenders in Medicare as providers would be the hospitals, prescription drug benefit, and physicians.

Hospitals are a very powerful group. With 5000 different hospitals, they're often the largest employer in most towns, and we just passed legislation giving rural hospitals more money, and notwithstanding the MedPAC recommendations and the point is, Point Four, it's difficult to extract savings there.

On the prescription drug benefit, I think on a bipartisan level, most people don't want to tinker with that before it's gone into effect, and President Bush particularly issued a rare veto threat, saying he didn't want anyone taking prescription drugs away, so I would consider that off the table.

And then, of course, the physicians, the third-largest part, are confronting a five percent cut in 2006, and five percent cuts thereafter, every year for seven or eight years, what I call the "Bataan Death March." If that's allowed to occur, the Medicare program will turn into something like

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Medicaid, in my opinion. So, there are not a whole lot of options, and I think people often forget in the MMA we did save $75 billion over ten years, savings from things like billable medical equipment, average wholesale price reform on the oncologists, home healthcare, ambulatory surgical centers, labs and the others, so the smaller providers were already hit, and if someone's putting a package together this year, they'd have to contemplate either taking on those three big pieces of the Medicare pie, or trying to extract even more savings out of the providers that were already hit, which would be quite difficult.

That being said, I think that the leadership and the committees have not resolved whether Medicare will be part of a reconciliation bill or not; it's still open to debate.

Moving down the list would be Medicaid. I think there's a grave concern in the federal government about how much is being spent on Medicaid. It's doubled nearly every decade, 50 percent up since 2000; Chairman Barton noted in the recent hearing that Medicaid spending has eclipsed education for the first time in many state budgets. It's slated to grow 7.6 percent a year. It's going to double again. There was a significant F-Map increase in the 2003 tax bill. Just great concerns about that, and the President's put some ideas on the table, to slow the growth rate of Medicaid by about a half of a percentage point. Forty billion dollars would go after various

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state funding schemes and governmental transfers. Fifteen billion dollars would try to reform how Medicaid pays for prescription drugs, much like we did on Medicare, moving from an average wholesale price, AWP—I used to refer to that as Ain't What's Paid—the average sales price, then $4.5 billion, looking at asset transfers from middle-class families who try to look like they're poor to try to get in Medicaid and long-term care.

Which brings us to the larger question: What are we going to do about long-term care, when about a third of the Medicaid population's consuming two-thirds of the Medicaid resources? It's really a challenge to think about. I think there's a lot of interest in Congress to try to make Medicaid a higher quality program, and reform it. I think there's a lot of frustration with how it works, how expensive it is, and the quality of care that many are getting under state government schemes.

Lastly, I think it's noteworthy that the President proposed a substantial uninsured package. Notwithstanding the budget deficits, he included in his budget exactly what he campaigned on, $40 billion, including $16.5 billion for Medicaid. Noteworthy of that would be trying to cover our eligible kids under the Cover the Kids Program and those under S-Chip as well, and of course, there's refundable tax credits directed towards lower and middle-income individuals who don't

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have employer-sponsored coverage, about $75 billion in the high risk pool. I think that's very significant. The House in the past has included the President's budget on the uninsured in their budget resolutions. I'm hearing they'll do the same now. Obviously, that's not decided. It's not clear whether the Senate will do that. Senator Gregg obviously is very concerned about budget deficits. Last year's budget resolution in the Senate did not have funding for the uninsured. As we know, we didn't have a resolution between the two chambers, but I think that the uninsured is still an issue out there. It's still important that the President put it in his budget, and it's my hope, being and outside observer, that this gets some attention and we don't just focus only on Medicaid and Medicare, but that will take real congressional leadership and presidential leadership to get that done.

So I'll stop there, and listen to my colleagues' remarks, and of course answering and hearing you guys' questions. Thanks.

ED HOWARD: Thank you, John. Cindy?

CINDY MANN: Thank you. Good to be here. I do have some slides. I'm not going to go through all of them, you'll be happy to hear, but hopefully some of them will provide some background into some of the issues that will come up in some of our presentations and some of the questions.

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I'm going to talk about Medicaid and the State Children's Health Insurance Program and how they fit into the President's budget, and where they may go. I think if I were to say one thing about what I see in the President's proposal, I'd say what you see is probably not what you will get, tut there are the signposts there to suggest a clear direction into which we may be heading. I applaud this effort to start exploring and urge you to keep paying attention, because I think it will be a very significant year for both Medicaid and the States' Children's Healthcare Insurance Program.

The first couple of slides are really to try and put the Medicaid program and the issues around Medicaid into context. It is a very large program. The costs are significant. Healthcare costs have generally been rising, but it is not, I think, by any means an uncontrollable spending in the sense of where's the money going, and why are we spending all this money? The first two slides slow you—so I'm looking at Slides Two—Oh, I should be doing that, right?—Slides—or I won't.

ED HOWARD: Or you won't. We can do it for you.

CINDY MANN: Can you do it for me? The first two slides show you that on a per-person basis, once you adjust for health, Medicaid actually spends less per person than the private sector, and the second slide shows you that the rate of growth in Medicaid on a per-person basis has actually been

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slower than in the private sector. That is not to say that there aren't significant cost pressures for states as a result of rising Medicaid costs. Healthcare costs have been rising faster than state revenues, and the program has been doing what it's intended to do, which is a cyclical program. So, as employer-based coverage declines—people lose their employer-based coverage due to the downturn in the economy, Medicaid picks up a lot of that coverage. So there certainly are cost pressures.

I'm not going to go to the slide, but I'll refer you to the last slide in my package, anticipating that we would hear—and we already did—that Medicaid squeezes out education. I urge you to pay attention to the details. If you have the handout, if you look at Figure 22—You don't need to flip to it in the overhead—The analysis that often goes on is looking at Medicaid and state budgets and it counts the federal dollars along with the state dollars. If you look at what states are spending of their own state dollars on Medicaid, it is still a big cost pressure for states, but it goes down considerably and is far less than education, and I suggest that when you think about the Medicaid squeeze in state priorities, it's important to look at the state's spending, not what the federal government provides states for Medicaid, because that actually relieves state burden and helps states free up dollars for education and other priorities.

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So, there is a problem in Medicaid. It often gets misstated in what the problem is. I think in many respects this budget, if it goes in the direction indicated, will make those problems worse rather than better. The President's proposal—now at Number 4, thank you—would cut the program spending over ten years by a little over $60 billion, but the net reduction is a $45 billion savings for the federal government, and most of the savings would come in an increased cost-shifting to the states, making what I think is already a problem in the states far worse. Go to the next slide, please.

To put the number in a perspective, the net amount of reduction and the CHIP programs is really in the Medicaid program—over ten years, the $45 billion—is about the same, a little more, than what the entire federal allotments for the State Children's Health Insurance program was for the first ten years of the program. The program was started in 1997, was authorized until 2007. So the net reduction in Medicaid is more than all the federal dollars being spent on CHIP over the first ten years of the program, and a little less than what the federal government is proposing to spend on CHIP in its second decade. So it is a big reduction in terms of the opportunities to provide better access to coverage and stabilize some of the issues in the Medicaid program. If you look at the policy proposals, this is where I think it is either clear that what you see proposed isn't necessarily what I think we're going to

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get. [Inaudible] policy proposes about $40 billion of the $60 billion in net reductions. In changing house, the federal government would pay states in a variety of ways. It's changing the rules on what's called intergovernmental transfers, changing some of the rules on provider taxes that states impose to raise dollars to meet their share of the Medicaid program, and also counting the amount of federal dollars states would get for their administrative costs. Those would all deepen the hole for states. It would not just reduce federal spending in Medicaid, but it would also likely increase state saving or it certainly wouldn't result in state savings on the state ledger. But I do think it provides some good sound advice that we're trying to control spending in the program by making sure that states use the money wisely, and I also think it brings governors to the table.

The IGT proposal in particular is one that has been proposed for about a year by the Administration. Last year they came out with a proposal. They have never put a proposal in writing as to what they're talking about specifically in terms of IGT. They would affect various different states in very different ways, and it is impossible to figure out what is a proper intergovernmental transfer. States and counties, for example, all the time pass money back and forth to each other, in quite legitimate ways, in what may be improper intergovernmental transfers.

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There's also about $20 billion in reductions that would produce some states savings as well as federal savings were they to be enacted—changes in the drug prices, and some changes in the transfer of asset rules that would affect people going into long-term care in the Medicaid program. These, I think, are not tremendously likely to be enacted, but interestingly enough, I think the drug pricing, if the Administration's theory about it is one where you could get a lot of agreement. Beneficiary groups agree with it. It makes a lot of sense. It's a good way to do some cost containment. Many of the states would agree with it, but as you can imagine, there would be quite a considerable degree of resistance were that to be seriously considered in Congress.

There are—if you look at the next slide, Figure 7—some policy proposals that would then increase spending in the Medicaid and CHIP programs, mostly, again, in Medicaid. And that's what brings the $60 billion in savings to $45 billion in net savings. And, again, none of these are new. The biggest element of it is $10 billion in new outreach, the effects of new outreach. The President's proposal proposes a billion dollars in new outreach grants to increase children's participation in Medicaid and CHIP, but the biggest chunk in the new spending is the projection of added costs for covering more children. What's not said here is that the federal government plans to spend $10 billion in added costs. That

only leaves $7 billion for added costs for states. So it's not clear if these outreach grants will be taken up by states who are feeling already hard pressed by the costs in their Medicaid program.

Let me point out, and then I'll leave the others for general discussion, what I think is a little under the radar screen here in terms of the policy proposals is the call for Medicaid modernization. The President has proposed in unspecified language—I'm on Figure 8—undefined new flexibility in the Medicaid program that would be budget neutral to the federal government—no new federal costs—and as part of this he's proposed to accelerate the CHIP reauthorization. CHIP is up for reauthorization in 2007. The President's budget says let's do it in 2006 and presumably combine CHIP reauthorization with the Medicaid Modernization Effort, and looks at CHIP and waivers for the model for the Modernization Effort. Both of these initiatives, waivers and CHIP, operate within the confines of a cap on federal funding.

So I think we're just beginning to see what may transpire over the next few months in terms of Medicaid debate, and I'll close with some of the key questions listen on Figure 9. First of all, follow the money. Will there by $60 billion in cuts reconciled to the committees? Will there be 45 billion? Will there be less or more? There's a lot of concern among providers in states about that dollar amount and hoping

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to get it lowered. Will the policies that are proposed be adopted likely to go quickly by the wayside and other policies be substituted? And what I would suggest is one of the key issues is what's meant by modernization: flexibility to do what? Nobody is opposed, of course, to the idea of flexibility; it's always a good thing to be flexible. The question is, to be flexible to do what? And will that flexibility improve and not harm states' ability to ensure that vulnerable populations get their healthcare that they need. And, as I'm sure Ray will go through, we need to look carefully at the impact on states and localities. Medicaid is that largest source of federal dollars to states. It will have a major ripple effect on not only states and the local economies, but on the healthcare system. Medicare represents about 17 percent of all healthcare spending in the nation. Big impact on providers. Providers are very much interested in this debate as it goes forward, and of course, on the major impact on beneficiaries. [Inaudible.]

ED HOWARD: Thank you, Cindy. Now let's move to Gail.

GAIL WOLENSKY: Being the third speaker, always means you have to revise what you were going to say, because people have said some of it. Ray, that's a hint that you'll have to do even more.

I think the budget is more or less what most of us should have expected, in that health is not a major focus.

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That was clear from the President's statements about what his major priorities would be in the second term—that is, Social Security and tax simplification. That means, both in addition to financial ramifications of trying to reduce the deficit, the major committees that deal with healthcare issue, Ways and Means in the House, and the Finance Committee in the Senate will be busy considering the President's proposals for those two areas, which would make it very difficult to do very large new legislation in those areas. In addition, I think we all understand, as John McManus has said, the major focus with regard to Medicare is, and at this stage should be, implementing this new legislation that was passed in 2003, the Medicare Modernization Act.

I believe it was unfortunate that the Modernization Act, providing a major significant new benefit to seniors, was passed without the ability to change Medicare for the future—a little bit of eating dessert first—but in all honesty, I don't think there was the political will to take on these issues of Medicare as we look out into the future, so I believe it was either providing this new benefit now, or waiting until some other time when the Congress was pressured enough to do something about Medicare financing and also providing the new benefit at the same time.

It is not just a revenue problem with Medicare. Sometimes if you hear people talking in Washington, "Oh, if

we'd only been more ready, or if we'd hadn't had the tax cut, we would not have had these issues." In Medicare at least, in Medicare and Medicaid together, when you look out over the horizon, it is first and foremost a spending problem in addition to whatever revenue shortfalls may be on the table. Ultimately, if we don't find a way to get Medicare spending off of this historic average growth rate, which by the way will probably mean getting healthcare spending in general off of its historic growth rate, we will absorb enormous amounts of dollars out in the future in these two entitlements. Were we to project out as far as 2040—we have trouble projecting for five years, so I'm not suggesting we take these for real numbers—we could spend all of our current federal budget on Medicare and Medicaid if we keep at historic trends. If we do much better we could spend 60 percent of our current federal budget, 20 percent of the GDP, on Medicare and Medicaid. So we have some big issues about how we can change these historic spending rates. It is not happening now. It will probably not get on the table for another ten years when the pressures of Baby Boomers and the growth of numbers of people on Medicare, and probably on general revenue from Parts B and D of Medicare, both are which are financed out of general revenue, plus the seniors' premiums and coshare begin to cause enough pain to produce action.

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Let me talk a couple of minutes about Medicaid. I'm going to try to put in context what is being proposed, which is very small changes, and talk about a couple of bigger issues that are remaining on the table. The first is, what the President is trying to do is take a 7.4 percent growth and reduce it to 7.2 percent. John, I normally would defer in terms of numbers—he follows these much closer—My understanding is, because the spending was a little less than was actually anticipated, that what the President is proposing is even a little smaller in terms of reducing spending, about two-tenths of a percentage point over this ten-year period. The question is, is that something that could reasonably be done. I was asked this as part of the budget hearing that Ed mentioned yesterday. I think the answer is maybe. Maybe, because so little has been tried on the aged and disabled side, and it might be possible that you could do a little better there. Most of the attention in experimentation has gone with the moms and kids side, which as Cindy has mentioned, and John, I think, also mentioned, two-thirds of the people but only one-third of the money for the moms and kids. The aged and disabled are the smaller part of the numbers of enrollees, but where all the bucks are, and there hasn't been very much experimentation to try to do it better, smarter, cheaper. Maybe there's a little bit there. The biggest part of the increase in spending is on the Cover the Kids. Yes, of course, if the feds spend more,

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the states will spend more. That's the nature of a matching grant program. My concern, as a former administrator, has been with the states' creativity in terms of their financing. I want to encourage it in terms of their delivery. I have been more uneasy about their financing. We'll see whether we get anywhere or not with their intergovernmental transfers. That doubled my time in terms of creative financing. We knew it was a problem; we couldn't figure out how to fix it. I don't know if they figured it out any more. I'm sure the governors will appropriately push back and members of Congress may or may not follow through with this.

We desperately need to rethink Medicaid. Medicaid, particularly with the issues with regard to creative financing and the stresses on what was supposed to be a matching program not always being a matching program, but also, as Medicaid has expanded to provide many different functions other than for the welfare population, it needs to be rethought about how it fits in with other treatments of low-income populations, and making sure that integration makes more sense. It very much needs to be rethought with regards to the aged and disabled. We heard how the growth in Medicaid spending was largely attributable to an increase in enrollment. Not so surprising, when we've had a slow job growth recovery out of a recession. What most people haven't bothered mentioning is actually, it was more of the growth in the aged and disabled that caused the increase in the

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spending and not the moms and kids, and that wasn't obvious that you would see that in a recession time. So, this issue about how, and the responsibilities, and what is an efficient treatment, and can we find better coordination for the dual eligibles, a relatively small number of people who spend a lot of money is a very important one. I am reticent to suggest putting up yet one more commission, because that usually is just a stall tactic, but I think actually, having a commission of people appointed by the Congress, from the governors, from the White House, to think about a new Medicaid program might be helpful. Maybe now, at the beginning of a second Bush term—if not now, for sure very early in the next administration, because you could really do something more easily, but that may be too long to wait, so maybe now would be a good idea.

And finally, with regard to flexibility, two thoughts: The first is, Medicaid is the ultimate in flexible programs. We just make it more difficult through waivers. Anything can, and at some point has been waived in Medicaid. It's a question of how much time and duress we want to put the states under in terms of what they get in exchange for their flexibility. My offer is the following: I would propose a lot of flexibility with one proviso: In return the states provide better information on what actually happens in the health status of low-income populations. We have regulated Medicaid in many ways, and we don't know beans about what actually happens to

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the health of these vulnerable populations. If we could get that in exchange, I think flexibility is a small price.

ED HOWARD: Okay. Thank you very much, Gail. Ray, you've got your marching orders.

RAY SCHUPPACH: Okay. I will say, I think states are sort of exhausted about Medicaid. This is a program now that has grown 11 percent per year over 25 years. It's gone from ten percent of budgets—and I am including the federal money—in 1985, to 22 percent in 2003. It's more than all elementary and secondary education, and if you look very closely at where that money is beginning to come from over the last few years, it's essentially coming from higher education. I would expect to see dramatic cuts in higher education if we continue with this particular Medicaid program.

States have an unusual problem, in that healthcare represents actually about 30 percent of their state budgets, if you include their employees and other components. So on one side, you've got very rapid expenditure growth being driven by healthcare. But unfortunately on the other side, states have tax systems essentially built for manufacturing economies in the 1930s and the 1940s, not tax systems for a service-oriented, high-technology, international economy of the 21st Century. So on one hand you've got very rapid spending, on the other hand you've got a deteriorating tax system, which means for every additional dollar of net output, you get a little

less revenues than you had before. A lot of that is because most of the growth in economies is in services, and we don't tax services in sales taxes. So we've got a long-run problem there.

I would say Medicaid, when you look at the numbers, is driven by two factors: One, general healthcare price inflation, which has been running at 4.5 percent for the last 14 years, and second of all, the caseload growth, and just looking at those numbers, it now appears that we will have witnessed at 40 percent growth in caseload over the last five years, an average of eight percent per year. It is not sustainable. We are getting hit on what I would call both sides. Both the fact that the demographics, the retirement of the post-war baby boom is now beginning to hit, the growth in those over 65 is growing rapidly, in those particularly over 85 is growing even more rapidly, and people getting more ingenious in how they move their assets. This is a no-win situation on the long-term care side.

The second piece that is actually beginning to scare me more now—I wouldn't say more, but based on previous looks—if you look just at the period 2001 to 2003, you'll see that employers pulled out, particularly of providing healthcare to low-income people quite dramatically. It went from 67 percent to 63 percent. That happens to be the same amount that public programs grew. What scares me is the restructuring of the

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economy continues, because we're service oriented, and more small business who don't provide healthcare, and now you've got the large industrial firms being hit in the international marketplace, you add all that together, and I suspect you're going to see wholesale withdrawal of employer-sponsored healthcare for those people under 200 percent of poverty. The problem is that this is that this is the only safety net available, and therefore everybody falls on that.

I don't have to go over the numbers in any detail, but it looks like what we're estimating total expenditures in Medicaid for 2005 is probably 330 billion. It's probably 35 to 40 billion—I'm talking about federal and state money—more than Medicare. We now have 53 million people on the Medicaid roles. I would agree also with Gail's comment that Medicaid is just a categorical program, that is, you can't integrate anything else into the healthcare system with it, whether it's Medicare, the employer-based system, or other components.

In terms of the President's budget, our kind of line in the sand is, we're looking for things that save the states and federal money, and those types of things, I think we would try to look at seriously and could support. There are a couple in the President's budget, the one on drugs, the one on asset tests are the types of things that we could support. We need more detail on it. The 40 billion in terms of upper payment limit provider taxes, we would likely oppose. Withdrawing that

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40 billion from the system would have to require cuts in other programs and/or tax increases. I can tell you right now, tax increases are probably not on the table. But again, it goes back to, sort of, it's healthcare or education, but not both.

The other parts of the—I'll pick up on a couple of the comments that are I think kind of interesting—we don't know what modernization is, but there are some hints, essentially, that there would be more flexibility in the benefit package, which means you might be able to go to an S-CHIP package. There's also $4 billion in the President's budget for purchasing alliances for states, which I think is an interesting concept, and then the tax credits. Now, depending upon how these work out, these could all be very big plusses, because my own personal view is that we can argue about whether Medicaid is an efficient program or not an efficient program, but I can tell you one thing flatly, we've got to develop other policies for these particular populations so that they don't come onto Medicaid. We always focus on Medicaid reform, or how do we create a more efficient program, and I'm fine with that—I think it needs to be done. But we really need to go on two tracks. We need to find other policies for the long-term care population, and we've got to find other policies for the low-income people. But there is a way, I think, depending upon how the tax credits are written and what the incentive is for individuals to take the tax credit or go onto Medicaid, with

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the state purchasing alliances, with more flexibility in going to a more basic benefit package for Medicaid. And the way that works is, if we can get a basic benefit package into the alliance, and then it essentially has a certain amount of market leverage it can bid, and then the tax credit people can buy into that as well. State employees can buy into it, and it can also be sold to small business. If you can do that and create a fairly large purchasing pool, then you've got the hopes of stabilizing that particular small group market, so, I think there's a real plus in the President's budget, the alliances, the tax credits, and the flexibility and modernization of the Medicaid program. The question is, we've got to be very careful about how those are written and what the particular incentives are on those three components.

So finally, we're on board with major Medicaid reform. We need to have it. This program is not sustainable the way it is. We can argue out whether states are gaming or not gaming, or the efficiency of it, but with that kind of a caseload growth, and concern on what's going to happen to the employer-base market, particularly on the low-income side, we've got to start thinking about alternative policies. Thank you.

ED HOWARD: Thanks very much, Ray. Time for questions. Please identify yourself and address it to a particular panelist, if that's your want. John?

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JOHN EIGLEHART [misspelled?]**:** John Eiglehart. The question's really, one, the 53 million number you used, is that in the number that are eligible for coverage, or the number that are enrolled?

RAY SCHUPPACH: I think that's the number that are enrolled at this time.

JOHN EIGLEHART: Would you agree with that, Cindy?

CINDY MANN: That's the number that—there are two different numbers that are thrown around—the CBO numbers and the Administration numbers are about $10 million less.

ED HOWARD: Ten million people.

CINDY MANN: People less than that, yeah. There's a difference in the administrative data. Gail talks about flexibility with the data. I couldn't agree more about having good data, but so far from that, it's not around the corner.

ED HOWARD: Is it possible that it's the difference between served in a calendar year, or versus an enrollment at a point in time?

GAIL WOLENSKY: No, I mean, it's the problem you have with the uninsured, that half the Medicaid population are on something else other parts of the year, so it depends, average served, or at an average point in time.

JOHN EIGLEHART: One other question for Ray. Would you regard, and would the governors generally regard the program that former Governor Lebanon [inaudible—off mic] scope of the

benefit package, and eligible [inaudible] model for going forward?

RAY SCHUPPACH: I don't know. That's what Tennessee did too, and in my mind, I think it's probably good to reduce the benefit package so that you can combine it in pools and so on for that healthy population there, but again, that's only going to put off the problem for a year or two. I mean, the problem is that the caseload is growing so rapidly, we need other systems for these people.

ED HOWARD: Yes, go ahead, Cindy.

CINDY MANN: Can I just say something about the Utah program, and there's a figure in towards the end of my presentation about how Utah financed its program. There's all this talk about Chevys versus Cadillacs, and I was trying to think of the right analogy, and I think it may be the Pinto, which is sort of unsafe at any speed. Not only is the package not really a Chevy—it has no hospital care, no specialty services, mental health services and so forth, but enrollment stopped in this new program very soon after it was initiated because there were no new federal dollars put on the table for it. The State of Utah really didn't have the fiscal capacity to carry it out, and the waiver allowed the state to simply freeze enrollment. So, it's a non-moving vehicle, and if that is the direction that we're going, one wonders whether we're

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moving forward in terms of providing real healthcare coverage for people.

ED HOWARD: I should say, by the way, that those of you watching the webcast, all of Cindy's slides, including the one she just referred to, are posted on our website at allhealth.org. Yes, Sir?

DAVE: I'm Dave [inaudible]. This is for Dr. Wolensky. In all the debate on national healthcare policy, where do the veterans fit in? And I'll make a couple of observations, that last year the State of Missouri did a study of the program. The veterans who were on the Medicaid [inaudible]. There are a number of issues surrounding veterans' healthcare that cross all bounds, and perhaps Dr. Wolensky [inaudible].

GAIL WOLENSKY: Well, the two major traditional users of the VA system are veterans who have had service connected disabilities, and those who are indigent under the definition of the Veterans' Administration, which is substantially higher than it is at any other definition, I think in the neighborhood of about three or four times higher than the poverty line that is closer to what is used in many states. So it is primarily low-income and service disabled individuals, but it does not account for the majority of the veteran population. The users of the VA system are five to six million out of 20 million veterans. I say that to try to get some perspective of who they're covering.

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There has been some concern that in the late 1990s with some legislation that was passed, some non-traditional users who are neither service disabled veterans nor indigent by the VA's definition have been using the VA to get low cost pharmaceuticals, basically. Seniors who are living near a VA facility and who are, under current rules, had to go see a VA physician first and go use the VA for their low cost pharmaceuticals that are priced off the federal supply schedule, and that that has had a problem of backing up the VA system so that those who are service connected, the indigent users were beginning to have trouble getting into the system. So, one of the issues is that we have a VA system that is pretty full, so if you're thinking about trying to have this be a broader model, it's already having some problems being backed up because some non-traditional users have been using it the last five or six years.

Furthermore, it looks like after 2010, there's likely to be a decline in the use of the VA system, and therefore some real concern about doing physical expansions to have care for what might be short-term increases. So, I would say, the notion of thinking of the VA as a place to increase users under the current world doesn't make much sense. It does, of course, raise the question about whether or not one strategy that you might want to think about for low-income or otherwise uninsured populations are "specialty facilities" or hospitals for these

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populations. That's sort of how we got into the public hospital business, but they have much broader activities as do academic health centers to treat low-income or Medicaid populations that might [inaudible] the spirit of what you're thinking about, but not actually physically rely on the VA.

DAVE: To quickly follow up, hospital [inaudible] aside though, the effects of the current policy are forcing people out of the VA healthcare system onto the state Medicaid roles, for example, and other programs? The impact that is pretty catastrophic [inaudible].

GAIL WOLENSKY: I don't know of any programs that are doing that. The changes that the President has proposed was to introduce copayment and a premium of $250 for the non-traditional users, that is, people who are not indigent and who are not service connected, who have been coming into the system, so, I'm not sure why you think that's happening.

DAVE: Well, they could be the uninsured as well. [Inaudible]

ED HOWARD: Okay. I should say by the way, both John McManus and Gail have to leave at about 10:30, so you might want to concentrate your questions before then if you want to get them to do it. And I've also been asked to repeat or summarize the thrust of the question so that the webcast folks can know what you're talking about, even though you don't have microphones. Yes, down at the far end?

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MALE SPEAKER: I have a question about savings from flexibility. Dr. McClellan has said that there's no intention of the federal government to save money through flexibility, that the outlay would be the same. It seems to me the states would use flexibility to try to get their costs under control, that that would obviously affect how much the federal government would be matching. Just wondering how you see that? Are either the considerable federal savings [inaudible]?

ED HOWARD: The question has to do with the fiscal implications of the flexibility proposals. Yes, go ahead, Ray, Cindy.

RAY SCHUPPACH: Well, they're not huge, in all honesty. I think the types of flexibilities would be going to a different benefit package for some populations. It would be copays and things of that sort. But when you look at CBO's costing of most of these, I would argue that they're relatively small. I suspect not more than $6 or $8 billion for each one over a five-year period.

CINDY MANN: Let me respond a little bit to that. There's an important interplay between flexibility and financing in Medicaid, and how it works now, and how it might work under a new proposal. Right now, there's with open-ended federal financing, but clear federal standards about what a state can do with those federal dollars. If you get rid of those federal standards, states can use dollars in a multitude

of ways, and so it is often assumed that if there is very broad flexibility in Medicaid to use the federal dollars in lots of ways, including paying a school nurse, or things that don't quite meet the Medicaid definition of coverage, that the federal government would have to accompany that breadth of flexibility with a spending cap so that the federal government would not be exposed to big new costs. So how much flexibility is given will also relate to what kind of financing proposal will need to be put on the table for the federal government to protect itself in terms of Federal Treasury expansion, expenditures increases.

And I just want to also point out, it was said during the fiscal 2003 debate when the President proposed capped allotments to states in Medicaid for certain populations, anyway, that those capped allotments would grow consistent with federal government projections of the cost growth in the Medicaid program. If you look at Figure 11, if there is a cap on spending, whether it's the entire Medicaid program or a part of the Medicaid program it will appear in first instance, and in inside the Beltway scoring that there's no federal savings, but over time, if actual healthcare costs are more than what that cap is, than what those projections are, there'll be big federal savings and cuts to the program. This Figure 11 shows, if you look at CBO's projection for federal Medicaid spending in 2003 versus what their projections were in 1999, versus what

actual spending was in 2003, there was a big difference. Had we had a cap on the program in 1999, that wouldn't have been scored as having any savings, but in reality, it would have reduced federal expenditures.

JOHN McMANUS: If I can jump in on this, that's a very interesting hypothetical argument, however, that's not what the proposal is this year. So, I thought our task this morning was to talk about what's the 2005 President's budget, not past budgets or other block grant proposals, which aren't on the table right now.

ED HOWARD: John, do you want to talk about what the difference is between what's on the table and what Cindy was describing?

JOHN McMANUS: Well, clearly what's on the table for savings are the things that we've all been talking about: intergovernmental transfers, prescription drugs, looking at how people transfer their assets so that they can qualify for Medicaid coverage for long-term care, things of that nature. Block grants, which is what my colleague down there on the left, no pun intended, is describing, are not on the table as far as I know, and not in the President's budget documents, and I don't think they're being discussed with the significant battle that's going on with the governors throughout the last several weeks. Maybe Mr. Schuppach may want to get in on this.

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RAY SCHUPPACH: The Secretary's been very clear that the mandatory population would never be in consideration of a cap on it [inaudible].

CINDY MANN: Right, but just to be clear, first of all, the question was about, can we expect federal savings if there is a good deal of flexibility? I was suggesting that when you get into the area of flexibility you have to get into the area of financing because of the interplay, and the President's proposal does, in the discussion about modernization, talk about increasing flexibility within the context of maintaining current federal spending. I certainly agree there is no particular proposal now on the table that is, at least, clearly identified to cap allotments to the program, but I go back to my first remarks, which is, what you see isn't necessarily what you're going to get as the process moves forward,

GAIL WOLENSKY: But this is a program that, if the states want to cut back, the states can cut back. What the flexibility is, which at least to me, makes immanent sense, is, rather than force an all-or-nothing coverage for the optional populations, allow the states to have optional benefits, or to provide some benefits for the optional populations. If the states get pressured enough and they want to cut back, they have the ability now to do so. The question is, can they do it smarter or not? It depends what the states want to do. If they want to increase, expand their coverage, they can do so, if

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they want to cut back, they can do so. My concern—you do want to try to make sure that when they do so, they're putting their money into the pot. Cindy talked about having money get diverted to other ways. There were too many stories that when creative financing was at its height during periods of the 1990s that states were bragging about how they were taking the money that they were saving by only getting federal dollars, by putting it into highways and education, and sometimes putting it into healthcare. It's hard to have a program that's designed as a matching program when it doesn't always get the state dollars on the other side.

ED HOWARD: I want to make sure that we can pursue this. Is your question about this topic?

FEMALE SPEAKER: Yes. [Inaudible] in 2003, your NGA task force made a proposal [inaudible].

RAY SCHUPPACH: Well, back in 2003, they had trouble coming to consensus on where they were. We never really got into serious negotiation with the Secretary, but the block granting approach, in terms of total programming, was really off the table then, and I think it's still off the table now. Whether it's some alternative with respect to the optional populations, I don't know yet, to be honest. You know, it has not been discussed in any of our conversations. Nobody has ever put the term cap, limit, allotment, on the table.

FEMALE SPEAKER: [Inaudible.]

RAY SCHUPPACH: Right. That has not been part of any discussions, either.

ED HOWARD: Yes, John.

JOHN: I'd like to get the views of all the panelists on the following: If you set aside the relatively few people on Medicaid that try to game the system by hiding assets and that kind of approach, and just look at the general population within the framework of our society, most of these people are poor, have very few assets, and the question is that whether you agree that within the framework of the US, these are people that deserve to be covered and they're worthy of coverage in the US, and really, the question is, who should pay for it?

GAIL WOLENSKY: Well, let me first say that I'm not quite ready, because I don't know that we know enough about how serious the asset transfer is with regard to long-term care, nor have we done things to try to minimize the encouragement, and what I'm thinking about is the skepticism and scorn that has gone for the long-term care partnership program that the Robert Wood Johnson has helped promote, which I have thought for the last 12 or 14 years, however long it's been around, is an incredibly sensible program where you can buy insurance, protect assets for most old people, their house, and that doesn't count in your spend-down because you have the protection of your insurance. It gets used rather than your house, and then if you still spend more, you go onto Medicaid,

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and for reasons I have never understood, has been resisted by Democrats. It's again in the President's budget. It hasn't gotten much attention. It would help try to discourage the real lucrative business both in Florida and New York of elder law, and in fact, provide people who want to protect it, act fiscally responsible with the mechanism.

Having said that, we need a program for low-income people, people at least below the poverty line. I think it's a governmental function. We can decide whether it's federal or federal/state, and one of the big missing parts of Medicaid or some program that integrates with it is a third of the uninsured population are below the poverty line, and for sure they need to be covered.

I think the biggest problem with regard to the dual-eligible and the aged disabled part is, it's totally uncoordinated, so we have a group of people who are poor and sick by their nature, who spend a ton of money and who sometimes get incredibly uncoordinated care because they're in these two separate programs. Whether or not there's much possibility with community or home-based care for those that are now in nursing homes, I don't know. I've been impressed that the number of people who are likely to come into home and community-based programs will overwhelm any savings of people who might be in nursing homes now who could be treated on a home and community-based basis, but we'll see. I think it's

terrific to go and try that. I've not been impressed that there are a lot of savings, but below the poverty line, these are people who need to be, if not on Medicaid, whatever we call the other program of low-income support.

ED HOWARD: Go ahead.

RAY SCHUPPACH: I would just say that from a Federalism standpoint, I think first of all, I think you put the right question on the table. We think we cut a deal with the federal government many, many years ago, which was, you take people over 65 and we'll take people under 65, and that works for Social Security, it works for Medicare, and it works for all of the other programs that we run, in terms of welfare and so on. Now, a lot of these may be funded partially by the federal government, but states run them—some like food stamps are federally. . .That works really, with the exception of Medicaid, that somehow, if you're over 65 and have decent income and decent health, and now you're in a federal program, and now your health deteriorates and your income deteriorates, you fall out of a federal program into a state and local program. It makes no sense. There ought to be a continuum. It ought to be federal responsibility at some point. Plus, I would argue that the distribution is important. Low-income elderly don't locate in any uniform way across the United States, so there is a redistribution affect for those people, and I think that's a very legitimate way to go on. I think

we've got some rules of how we view this sort of federal/state component. I think it works in a lot of programs, but it does not work in Medicaid, and it gets worse all the time. We thought we cut a pretty good deal with the clawback, but we now find it's costing us more money.

ED HOWARD: Ray, you didn't mean to say that people, when they get sick over 65 fall out of the federal program-

FEMALE SPEAKER: Or into the state in addition.

RAY SCHUPPACH: They just get added on, okay.

CINDY MANN: Let me comment, because I do think, John, that that's the right question, although I would add, it's a question of commitment to cover the uninsured, and then should be say that out loud and then debate who should pay? But I also would go back to one of Gail's initial comments, which was, we need to do something more broadly about cost containment within the broader healthcare system so that we can all afford the healthcare, not look at a piecemeal, program-by-program, because there's too much pushing and shove form one to the other systemwide.

But I think as the comments indicate, we have two separate conversations. On one hand, you talk about low-income working households, people below 200 percent of poverty. Then I think we have the tension between should it be public programs or should it be employer-based coverage? And as Ray's remarks show, we are increasingly moving to public coverage

programs or nothing—public programs more for the kids, nothing for a lot of the working adults, and that needs to be addressed frontally. We have each sector pointing to the others. Should it be the employers that do it? The employers say they can't handle it and they are walking away from it for a lot of sometimes quite legitimate reasons. I think we see increasingly the public coverage, in one way or another, is going to be the basis of coverage for low-income households. The question is, how do we finance it, and are employers part of that story? Can we do a better job in Medicaid and the private sector of marrying the two?

Then we have a very separate conversation on the long-term care side, because then I think it's really the issue of the federal government versus the states, and that's where the immediate cost pressures are for the Medicaid program. It's about 42 percent for Medicaid costs, is filling in the gaps for Medicare.

If I can add, this, John, a slightly different perspective. Obviously, healthcare costs are pressure on state and federal governments. I think we need to step back and look at the societal view that it's probably not a bad thing that we as a society are spending more on healthcare as a percent of our GDP and will continue to spend more than we have in the past. They prefer it, good. People like healthcare, and it costs money. The question is, who's making the decisions? One

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of the things I like about the President's budget, and some of the remarks Gail has made this morning, is to try to empower individuals to try to take better care of themselves. The long-term care is a great example of that. If we can get people to say while they're in their 30s and 40 and 50s, and use the time-value of money to buy long-term care insurance, that would relieve a lot of pressure off the states, and later the federal government. Would that bring down the costs of healthcare to society? No, but it makes that sure that they're providing for their own healthcare. Obviously it's both the federal government's and the states' governments—i.e. the society's—role to take care of those who can't take care of themselves, and off the hand was debating that. IN fact, I think it's noteworthy that the President but $12.5 billion on the table to go after those who are eligible for Medicaid next year but who are not enrolled. Some people see that as costing states more money. So what? They're entitled to that. I think that's a very positive thing. I think overall we need to think of whether—we're going to be spending more money on healthcare—what's the most cost-effective way to do that? Can we do more on the prevention side, more disease management? More people taking more responsibility for their own lives, or are we going to rely on health plans or government edicts making decisions for people on how they ought to get healthcare.

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GAIL WOLENSKY: I'd also like to comment that while there is—if you don't look too much at the details, it sounded like there was a consensus and agreement—Cindy slipped in a couple of concepts that for me, I'd like to say, I'm not buying into, which is, I was talking about people below the poverty line. She wants it 200 percent of the poverty line. I think the question is the obligation. At what stage—is it fully funding at the poverty line, is it fully funding at 200 percent of the poverty line, or 300? That's where it think a lot of issues will get debated, and it's a question of whether or not there's publicly financing as a portion of this as opposed to, again, fully funded as is true with some of the public programs. These are the hard decisions that we have not yet come to some consensus on, as we go forward are going to have to decide where it is that we agree and move forward. It's why when I talked about it, I said, let's talk about who are poor according to our federal poverty line definitions, because I think there's the most agreements there, that at the very least, let's take out the one-third of the uninsured who are technically poor—the people who are on the Medicaid program who are technically poor and below the poverty line by the time they qualify. Where they were before is harder to tell, aside from the areas where we have some agreement, and then see whether we can go up from there, but it's why when you hear people talking about it, you ought to immediately get into what

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is it when they mean, especially when they use terms like a low-income population, is how are they defining it? Cindy did, on that, but I think that's where you start to get a lot more disagreement of whose responsibility is it when you start getting to 200 percent of the poverty line?

CINDY MANN: Let me just embellish on my comments, because I think Gail is right. That is the 100-200 is probably where there is the most debate, although let me underscore that there are tons of people who are below poverty who have no coverage source, and she's absolutely right that we need to pay close attention to it. If you look at the last slide—or one of the last—Figure 16, in the last, during the recession, some of the enrollment increases that Ray talked about were—the biggest enrollment increases were for children, most of whom were in the 100 to 200 percent of the poverty line, children in low wage families who no longer had access to employer-based coverage and Medicaid, and to some extent, CHIP made sure that we did not have more uninsured children during this last downturn, in fact we had fewer, notwithstanding the downturn, because of Medicaid and the CHIP program. I wouldn't suggest that it is a wholly state function in that income range. I think there are important opportunities to look at marrying your forms of coverage. I think Maine is doing some interesting work with small businesses and trying to link up employer-based coverage with its Medicaid and CHIP program, and

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that's the direction that we need to go. But if we withdraw and say, no Medicaid at higher income levels, we will have a situation where we have millions of people joining the ranks of the uninsured, because that is right now the no-man's land in terms of coverage.

ED HOWARD: One hundred percent, 200 percent, sounds like a question for a conference committee. We'll be back to do this program, to give you the results of the conference agreement. We have just a couple minutes left, so are there other questions that we should explore? Yes, Christine?

CHRISTINE: [Inaudible-off mic] hearing something on radio about [inaudible] and I could never quite figure out why the federal government couldn't just pay all these investigators [inaudible].

ED HOWARD: The question is about the nature of intergovernmental transfers, and how you tell good ones from bad ones.

GAIL WOLENSKY: Let me answer the second question, and my response to the first is, if we could have figured out how to draw that line in regulation or legislation, we would have put it forward in 1991 when we put forward the changes on inappropriate provider taxes and voluntary donations. And if you don't remember what that was about, the voluntary donations, the hospital would make a donation to the state in order to get matching money. The state would get federal

dollars, which was matched by this voluntary donation. It would turn around and return the money to the hospital that had put up the voluntary donation. There was new federal money; there was zero state money new into the system. So, that's the most egregious example, and the question is, when other money is churning, like money going from the state to the county or from the state to the local government, whether this is really new money that's going into the system or not. We weren't smart enough. We knew it was a problem, and some states were making excessive use of intergovernmental transfers. We could not figure out how to write a rule that would distinguish it, and the reason you can't send in the IEG is because there's not a specific regulation against it. The fact that it is clearly against the spirit of the states putting up new money doesn't give you a position to go back and collect it, and even if you did, if you could legally, the pressures from the governors to cut it out on the feds seems to be too great to have too much activity go on. They may know, but I couldn't figure it out.

CINDY MANN: Let me put a couple things in context and then try and answer the question. One is that when Tom Scully a few years ago was railing around these intergovernmental transfers, he was talking largely about the upper payment limit arrangement, and I just want to remind people that there was legislation in 2001 and in 2002 which significantly clamped down these clearly inappropriate opportunities to do some

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recycling of dollars, and states that used it heavily are now in a phase-out period, and new states cannot go onto that system. So there has been a very significant change over the last few years in terms of some of the issues that garner the most attention. There has also been, over the last few years, auditors placed in every state, and every state has had federal auditors, and every state has had state plan amendment and waiver plan amendments, and waiver proposals held up until there's satisfaction by CMS on the issues around intergovernmental transfers, even though the rules of the game are not entirely clear, and it has caused a great deal of acrimony between states and the feds because of lack of transparency over what it is they're looking for.

The issue of fundamentally why it's difficult is because some of the issues come in—The simplest example is there's a Medicaid payment to a county hospital for services provided to Medicaid beneficiaries, and then the question is, is it the county then provides some intergovernmental transfer back to the state. Is that really about cutting back on the Medicaid payment, or is that another intergovernmental transfer that counties and states do all the time? How do you sort through all the normal business of money passing between states and counties, states and localities, in both directions, versus scam arrangements that are about trying to draw down federal dollars without putting up the state dollars? So they're

difficult to identify, but we would be remiss not to recognize that there has been very substantial changes in the law and in the regulations over the last couple of years on this issue.

Okay. We have just about run out of our time. We really appreciate your participation in this session. Thanks to Robert Wood Johnson for helping us think through this session and their support for it. Thanks to our speakers who have been illuminating. I want to make sure that you know, if you are doing these follow-up stories and you have a question you can't figure out how to go forward with, Bill Irwin, our Communications Director is immanently qualified and anxious to be of assistance to you. We'll continue this conversation. Thanks very much for coming.

[END RECORDING]

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