Healthcare and the Economic Slowdown: Medicaid, State Revenues and Federal Spending Plans
Alliance for Health Reform Kaiser Commission on Medicaid and the Uninsured
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ED HOWARD, J.D.: Good afternoon. My name is Ed Howard. I'm with the Alliance for Health Reform and on behalf of our Congressional leadership Senator Rockefeller and Senator Collins and our Board of Directors, I want to welcome you to this briefing on how the Medicaid program that fiances health and long-term care for formidable Americans is affected by and has an impact on an economy that shows unmistakable signs of slowing down.

Our partner today is the Kaiser Commission on Medicaid and the Uninsured, which is a project of the Kaiser Family Foundation, which in turn does so much useful work in both health policy and communications. You will be hearing from the Commission's Executor Director, Diane Rowland, in just a moment.

You know Medicaid sometimes gets overlooked in health policy discussions in this town, which when you think about it is kind of an unusual occurrence or should be an unusual occurrence. The Medicaid program is huge. In the fiscal 2008, more than $350 billion, we just to say it had overtaken Medicare but you folks who put Part D in place kind of reshifted the balance a little bit but at least for the moment. Medicaid covers more than 50 million people. That is one out of every six Americans. In that respect, it is bigger

than Medicare, so when the economy starts to falter and people start losing their jobs, more people become eligible for Medicaid. That makes the program more expensive at the very time when state governments, which are of course required to balance their budgets every year, start losing revenues.

So, it really raises some substantial dilemmas for those involved with the program. We are going to hear a discussion about these problems from a number of different prospectives this afternoon.

So at this point, let me take the occasion to recognize my co-moderator and Kaiser Commission Executive Director, Diane Rowland. Her very impressive biographical notes are in your materials. Let me just say it is a real pleasure to have, and a comfort to have, one of the nation's most respected authorities on health policy moderating the discussion with me to bail me out. Diane thanks for being here.

DIANE ROWLAND, Sc.D.: Thank you, Ed and thank you for being so generous in your comments. I think as we gather today in this historic room it really is also part of the message of this briefing today, which is that history tends to repeat itself and let us hopefully learn lessons from the last time that we can apply to the next time. And so, as we

face yet another economic downturn and we look at the stress and strain that puts on state budgets and on the operation of the Medicaid program, I think we can look back and take some lessons from the last economic downturn in the fiscal stimulus package that was put together there.

I also think that it's worth remembering. We tend to think about Medicaid as Ed talked about it in terms of the 50 million beneficiaries who depend on it, those who are uninsured that may potentially become eligible for the program but we also have to remember that it's a major part of the economy and it's a major part of the economy of many small communities and towns around the country. I was reminded once when testifying before the Virginia legislature. I was talking about the impact of Medicaid cuts and one of the Senators looked up and said, "But that's the hospital in my community that employs the most people, that's the pharmacy where most people work." And so as we look at these issues we need to at them both from the prospective of the program and the role it plays for the people it serves but also for its overall impact on the economy.

So I'm really pleased that we have such a great panel today to really share with you some of their thoughts and their insights on where we are today with regard to Medicaid and the economy and where we ought to be going. So without

further ado, I'll turn it back to my co-moderator. Thank you.

ED HOWARD, J.D.: Thanks Diane. A couple of logistical notes before we go forward. Many of you who are regulars at these briefings have heard them before but bear with us. There are some new folks. By Tuesday, you will be able to view our webcast of this briefing thanks to kaisernetwork.org, a project of the Kaiser Family Foundation. In a few days, you will also be able to see a transcript both on the kaisernetwork.org website and on the Alliance's allheatlh.org website, along with electronic copies of all of the materials that you have in your packets. And in fact, more because we have a PowerPoint presentation that wasn't available in advance that will get posted on our website right after the briefing.

We are going to ask you to be an active part in this discussion once we get the presentations on the table. There are floor microphones. There are green cards in your materials that you can write questions on and have brought forward. So, don't be reluctant to ask tough questions in a civil way. [Laughter]

Finally, we just ask you to take a second to turn your cellphones to vibrate or off so that you won't have to worry about people criticizing your choice in rings in the course of the briefing.

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Now we have got some very impressive speakers today and more than we usually have. So I appreciate their all coming together to help us grapple with these complicated and interrelated problems. I apologize for not being able to give them the introductions they deserve just because of the need for brevity. I would urge all of you in using these microphones, because the acoustics in this room are not that great, a lot of echoes around, that you get as close as you can comfortably get so that you can hear every precious word in the back of the room.

With that practical advice, let me turn to our lead off speaker and we are really pleased to have Dennis Smith filling that role. Dennis is the Director of the Center for Medicaid and State Operations with the Center for Medicare and Medicaid Services at HHS. His not very difficult job is to oversee the Medicaid program, which actually many people, describe as not one but 50 or more programs that are very different from place to place along with other non-controversial activities like the SCHIP program and others like that.

Now some of you may not know that before he came to CMS Dennis was in charge of the Medicaid program in Virginia so he has experience from both ends of this federal state relationship and we are really glad that you were able to

join us today Dennis to get this discussion off on the right foot.

DENNIS SMITH: Well, Thank you very much for inviting me. I'm delighted to be with everyone this afternoon and congratulate the Alliance on putting together such an impressive panel. I would like to sort of sit here and listen to them all afternoon but to earn my lunch I guess I have to say a few words and I'm happy to do so.

As Ed mentioned sort of Medicaid crept up on policy makers and folks I think in many respects didn't quite fully understand the growth in the Medicaid program. Medicare is the big game in town because the federal government finances all of its costs and runs the whole program etc. versus Medicaid to where 43—percent of the funding of the program is not in the federal budget. So it doesn't look as big here in Washington. But putting together of course Medicaid is going to spend about $350 billion this year of which about $200 billion from the federal government. And is projected to spend state and federal combined over $2 trillion over the next five years, over 5 trillion between '09 and 2018.

I think to some extent it has been stuck in my head last weekend, I saw Charlie Wilson's War. And one of the, I think, underlying themes of the movie of course is also how Washington works. One of the things that struck me was the

very modest five million dollar first appropriation that they were looking for and got doubled to ten, etc. They went back, sort of reflecting back on it is well how did this happen. Basically, the message was well nobody was watching.

To some extent, the growth in Medicaid has happened much in the same way. It has been sort of out of sight. It has grown over time both in terms of increased eligibility as mentioned. We now have between SCHIP and Medicaid combined, 36 million kids who are served at some point in time, which is more than the actual number of kids below 200—percent of poverty in the United States. Roughly, there are 30 million, 30.2 million kids below 200—percent of poverty yet we have 36 million that we have served at least part of the year.

So I think that again it's kind of, people hear about what Medicaid does for the first time. Medicaid has been given many different tasks. It has been, it started as a low-income program for individuals on the old FAPC program. People who are on welfare, people with disabilities, and our senior citizens who didn't have the means to pay for their long-term care, who was the essential part of the program. But we have heard things again over time like income disregards was really part of the lexicon last year in the SCHIP debate where income disregards started out in the welfare programs to provide incentives for people who were

already on welfare trying to help them get into the work force and leave the work force eventually. So it was a way of gradually getting them into the workforce helping to provide support over time. Now we have sort of turned it on its head and used income disregards exactly the opposite way to get higher income people eligible for the programs.

The current situation in terms of ETHMAP and the situations that the states face today, I really think are different than earlier this decade when a temporary ETHMAP was provided. In the sort of the old model, states basically had three choices to make when they were facing hard economic times what they would do in the Medicaid program. Essentially their choices were to cut eligibility, cut benefits, or cut payments to providers. But since that time and since the last ETHMAP increase we saw the passage of the Deficient Reduction Act of 2005, which has given states many of the tools that they had long asked for.

So one of the I think important considerations now is states now have more options to deal with their Medicaid program and the control of the program. We have seen some change over time, greater use. We have seen a great deal of growth in managed care in the Medicaid program but other things like disease management, so states have more tools to deal with the challenges than they did I think last time

around.

Also, and again I think the sort of again the historical relationship between Medicaid and the economy to where enrollment was sensitive to what was going on in the economy, unemployment in particular but this decade we saw that even after states came out of hard, more difficult times and the economy got better, enrollment continued to grow. And usually you would have seen the relationship as the economy had difficulties, the enrollment would go up, things would get better, and then enrollment would go back down. We didn't see that this time. Enrollment stayed the same.

Often times I think to a large extent states should be congratulated for their role in the leadership role that they have taken in trying to reform our health care system and to expand health insurance coverage. But what went well for the lower income categories, we can do something, do things differently though as you get into the higher income levels. Things like cost sharing for example. And we have seen states now; we have a state in the SCHIP program currently covering a 300—percent of the poverty level with a premium of $80 a month that the state now wants to cut that in half. You know at $80 a month coverage was I think arguably a very affordable for a family making more than $60,000 a year. So what is the rationale for simply saying we

are just going to cut that participation in half? We have asked the state, we are sort of still waiting for a good response.

Lastly let me touch as I've seen my time run down, touch on regulations that have been a popular topic of discussion here lately. And again to sort of put this in prospective. The savings associated with the regulations is a little under $14 billion over five year period of time. So, again put that into context of the $200 million program in itself. And in many respects as we have seen we get sort of go back and forth with the states where there is a lot of focus on the new rules. When you go back and look through Inspector General audits for example of state programs in these different areas, the states were meeting the old rules so in a large part the challenge was the new rules are sort of getting the blame for things that wouldn't have been allowed under the old rules had they been appropriately enforced.

So, I think the issue to some extent is coming down the enforcement issue and at the federal level or keeping the partnership intact of the funding of the program and the responsibility of the program. So my time has expired here and I look forward to your questions.

ED HOWARD, J.D.: Thank you so much Dennis. Now we

are going to hear from John Holahan who directs the Health Policy Research Center at the Urban Institute. John has done more analyses of Medicaid and state health policy than almost anyone around. And he is among the most respected voices on these topics so we are very happy to have you back on an Alliance panel, John.

JOHN HOLAHAN, Ph.D.: So I'm going to talk about some work that we have been doing with support from Diane and our Kaiser Commission on Medicaid and the Uninsured on the effects of an economic downturn on Medicaid, SCHIP, the uninsured, both coverage and costs. This is a joint product, Sean Durian [misspelled?] my colleague at the Urban Institute has sort of lead this effort but Bone Garrett and Emily Williams and I have also been helping out.

So let's go back over the basics of the downturn and how it affects health coverage, unemployment, and related pressures on business. It causes many people to lose to their employer-based insurance. Those who lose that either become uninsured which increases state and local costs of uncompensated care. They enroll in Medicaid or SCHIP, which increases state spending, or they get some other kind of coverage and at the same time and pretty importantly it turns out, states experience revenue declines that affect our ability to pay for Medicaid and to pay for uncompensated

care.

These are some results from work that has been done by Bone Garrett one of the co-authors. It's economic metric estimate of the impact of one percentage point increase in the unemployment rate, the number of children and adults with various types of coverage. If you look at kids, the model predicts that you would see a drop with a one-percentage point increase in the unemployment rate and that's probably about what we are looking at. In January, the unemployment rate was 4.9—percent. The forecast that I have seen range from 5.5 to 6.5. So a one–percentage point increase is useful to look at here. You see a drop of 700,000 children most of these will get picked up by Medicaid because Medicaid does and SCHIP together does such a, has such broad coverage for low-income children. For adults it would be a drop of 1.7 million, 400,000 picked up on Medicaid, 1.1 million uninsured. Overall, an increase in Medicaid of one million, increase in uninsured of 1.1 million.

WE then tried to project what that would mean in terms of Medicaid spending. The numbers at the far right hand side there show that baseline what we were in 2008, 335.2 billion, total spending 142.9 state. We project and this is based on the changes in coverage, our estimates of costs based on 2008 numbers adjusted for the fact that we are

likely to see less healthy or more healthy people come in than those who are on the rolls right now. The state cost in this would go up by 1.4 billion, overall 3.4 or one percent increase in overall spending.

But an economic downturn is more implications for Medicaid than that. It will have a pretty sharp increase or decrease or adverse effect on state revenues. A colleague of ours at the Urban Institute Kim Ruben has done a different kind of metric study that looks at the impact of unemployment on state revenue. Her findings are that a one –percentage point increase in the unemployment rate reduces state revenues by three to four percent. Now if you assume that all states must balance their budget and that all spending is cut proportionally then Medicaid and SCHIP would face cuts on the same magnitude, three to four percent

So revenue loss is really a bigger fiscal problem for Medicaid than increased enrollment. Together these two studies would say the states face about a 5.5 billion to 6.5 billion problem from just related to Medicaid from each one-percentage point increase in unemployment. So what does this mean for state budgets? I think it was said earlier by Ed that states, almost all states have to by law balance their budgets. To do this the behavior of states is to get into rainy day funds or reserves, borrow from trust funds,

security ties, future revenue streams the states have done through tobacco, settlement funds or they push spending into the next year; but once they get past that and the ability to continue to do those things then they start to increase taxes or cut spending on Medicaid or college education, aide to localities and things like that. These latter actions not the former but the latter ones are prociprocal that is they offset what the federal government is trying to do and they worsen the economic downturn.

So in the last recession there was legislation passed that provided fiscal relief to states. Part of this was in block grants, $10 billion, and the other part in increasing the federal matching payments by 2.95 percentage points over a 15-month period. The main stipulation was the states had to agree not to reduce eligibility standards below prior levels. The effects of this were reasonably good. States did not cut Medicaid eligibility during this period. It prevent a lot of other cuts although there were some made to benefits and provided payment rates but I think there were two problems. One is the delay in reaching federal agreement – but it meant that the delay in getting the legislation passed meant that many states had already made a lot of cuts before the fiscal relief was available. The stimulus needs to be quicker and more automatic for it to have the effects that we want.

Then the states vary a lot in the length and depth of an economic downturn as well as when those downturns begin and when they end. So a single uniform ETHMAP adjustment as the last time means that some states actually receive windfalls and were able to use the money to build up rainy day funds or reserves. And other states got a lot less help than they needed or they got it after they needed it. So it was both poorly timed and poorly targeted.

This slide is one way of looking at this that unemployment rates, at the end of last year, very tremendously across states. If you look at changes between the beginning of ’07 and the end you see a comparable picture considerable variation of how much unemployment rates have gone up, some actually have gone down but there are states that detail that have had greater than a one-percentage point increase just in ’07. And this is before we are all thinking that this recession was coming.

So, what to do about it? We could do what we did the last time. A uniform ETHMAP increase for all states, amount and duration determined it through the legislation. Essentially all states are treated the same regardless of their circumstances. The depth of the recession, how long it should last and so forth. We think there should – we should be thinking about an alternative that would provide federal

funds based on changes in unemployment. The GAO has written on this. That's one possible way to do it. It's essentially a national trigger. Unemployment goes up by a certain amount at the national level but then the funds are distributed depending on the depth of, depending on state circumstances, how badly off a particular state is. But I think even though there are a lot of ways to do this I think the principles here are these that the assistance needs to vary with the depth and the length of an individual state's downturn. It needs to begin and end based on the state unemployment changes, the individual states and that the funds need to be large enough to offset not only the increased enrollment which would be actually reasonably small, but also the fact that the revenue loss affects state's ability to support the base Medicaid program.

So to sum it up, when an economy declines Medicaid initial enrollment goes up, costs go up at the same time state revenues are falling, the number of uninsured which I didn't really spend any time on but that goes up too creating a different kind of fiscal problem for state and local governments. To balance their budgets states still have to cut back on Medicaid. This is could adversely affect the stimulus for trying to get out of federal policy.

The legislation last time in '03 and '04 did a good

job of preserving Medicaid eligibility and it helped states avoid many of the cuts they might have otherwise had to make but not all. And in part, this is due to the fact it's relatively crude mechanism and not well targeted.

So as we get into a new downturn we are going to recommend that states, that the Congress actually go ahead and design a stimulus package but that have it be much better in terms of it's timeliness and how well it's targeted. I'll close with that. Thank you.

ED HOWARD, J.D.: Thank you, John. A very good piece of background and overview as well. Next up is Jim Frogue. He is the Project Director at the Center for Health Transformation, an enterprise with which former Newt Gingrich has some vague connection. He focuses on Medicaid and state health policy there. Before joining the Center, Jim's worked with market oriented state legislatures on health issues at the American Legislative Exchange Council and he is also a veteran of several different Hill staffs and a previous Alliance programs. So we are very pleased to have you back, Jim.

JAMES FROGUE: Thank you very much, Ed. I appreciate the invitation to be here and you covering such an important topic. I think Dennis and his remarks said something that gets to the heart of the comments that I want to make which

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is about the movie Charlie Wilson's War. My first year on Capitol Hill to date myself a bit was 1996 and I was a lowly staff assistant. Even back then, I remember hearing stories about this legendary character named Charlie Wilson and all the activities he got away with and if you have seen the movie, you know what I'm talking about. I looked forward to many of those activities myself as I rose in the ranks on Capitol Hill. [Laughter] And at last, the movie was somewhat more exciting than the reality.

When we talk about health transformation, we talk about healthcare system that's entirely different than the one that we have today. One of the key qualities of a 21st century intelligent health system is transparency. The right to know costs and quality outcomes of all healthcare providers. The trend toward transparency is everywhere. Our government is becoming more and more transparent every day and one of the best examples of this in recent years is the transparency bill passed by Senators Coburn and Obama that $1 trillion in federal, there is to be one portal a not long website for people to search $1 trillion in federal spending. That's exactly the kind of reform we want to see.

Senator Obama is the most liberal senator. Senator Coburn is very likely the most conservative senator and this is something on which they could agree. Campaign finance laws

that require disclosure of everything over $200 even your salaries on LegislaStorm which if there is anyone who doesn't know that I'm sure that's the first website you will search when you get back to your office. [Laughter] Yes, you can find the salary of every one of your colleagues anywhere on the Hill.

In Florida, they have a website called floridahealthfinder.gov, which I would encourage you to take a look at where you can find costs and quality information outcome results for every hospital in the state. It costs the state of a couple hundred thousand dollars a year total to put up this very powerful sunlight effect. And by the way, 93—percent of people think they have the "right to know" cost and quality information about healthcare providers.

The Medicaid federal match, I won't spend much time on it, but the way the federal match works the dynamics, the incentives that it sets in place all but guarantees ever higher spending. It's an open-ended match anywhere between 50 and 76—percent. And it's a whole industry of lawyers and consultants in this town who make hundreds of millions of dollars teaching states how to gain the federal match. I'm Dennis Smith once he retires and steps down and has a few drinks may want to write a book about this.

The incentives for states are for every dollar of

Medicaid spending, they get one to three “free” federal dollars. Of course, that assumes that the taxpayers in the state don’t also pay federal taxes. To save a dollar in a state budget means leaving one to three federal dollars on the table. And as a result, state spending on Medicaid has gone up as a proportion of their state budget for 40 years. And that trend will certainly continue.

Medicaid is crowding out education, law enforcement, highways and environmental protection than any other state spending priority. But the federal Medicaid matches aren’t going to be fixed any time soon. So what to do?

Well to walk you through one slide to illustrate what I’m talking about, let’s talk about Medicaid in Florida and New York State. New York has by far the highest absolute per capita Medicaid spending of any state, 13—percent of federal dollars go to a state with six percent of the population. A *New York Times* study in 2005 in July found that there was one Brooklyn dentist who billed for 991 dental procedures in one day. Now there is not a McDonald’s anywhere in the world that would sell 991 phantom cheeseburgers in a day for comparison.

James Nisbet who is the founder Inspector General of New York Medicaid said, this is in the article, “40—percent, four zero, 40—percent of claims are questionable”. There was a private study done in 2006 that has never seen the light of

day that were the first outsiders to ever at look at New York's claims. They found one quarter of that program cannot be explained. Now New York Medicaid give or take is about $50 billion a year. So that's $12.5 billion in probably outright fraud.

Amusingly the Federal Medicaid Commission started in the summer of 2005 and had a year and a half to come up with ideas on how to save $10 billions from the federal spend over the next few years. And instead of looking at New York Medicaid fraud in which they could have found all of that in two years in one state alone, they recommended all kind of hits to honest providers.

Perhaps I can suggest a future Alliance for Health Reform event on ideas to combat Medicaid fraud because there is quite a bit of it. And the ultimate people that get hit are the providers and more importantly the patients whose state of care is restricted. We actually did a back on the envelope calculation last summer. This is not scientific so I'm telling you it's back of the envelope but if you took Arizona's Medicaid system, which is arguably the best run in the country and applied the principles of the Arizona Medicaid, the management of Arizona Medicaid to New York you would probably save at least $10 billion a year. Arizona by the way is the highest Medicaid reimbursement rates in the

country, the most satisfied providers, the most satisfied patients. They have a very good rural access. And it's a program that just works very, very well.

So, what to do? well if Congress is considering a bail out of states, it's appropriate for Congress to have an ask – in any relationship whether it's your husband or wife or state to state or business to business, relationship appropriately is give and take. So what can Congress ask?

Well, how about as a condition of accepting bailout money states must provide, must post all provider bills online for public access in real time. A little Coburn/Obama for Medicaid. Now I haven't spoken with anyone in Senator Obama or Senator Coburn's offices so they are not endorsing this. I'm just saying the principles that underlie what they passed for federal spending are appropriate for Medicaid.

So if you submit claims to Medicaid as a provider in your state that claim goes online in real time as soon as possible. And real time would be real time but in some cases there is paper bills and some delays at hospitals and cases so it might be something that can't go exactly real time but close would be very helpful.

So how do you do this? Work with states and provider groups to create low cost administratively simple way for provider billing to go online in real time. To get started I

understand this is a very sweeping proposal but in eight minutes or less I'm just talking about the concept here. In the Q&A, we can get into more details. But at the very least, you could talk about ten or 20 high volume services or procedures that are susceptible to fraud. You could limit it to fee for service Medicaid but areas where there is a lot of fraud for example durable medical equipment, transportation services, Cat scans and imaging, injectable drugs. There is a lengthy list. Then if you put sources and uses of state Medicaid funds and taxpayer dollars Dennis I'm sure it's not something that you would want to deal with, but it would be quite a sunlight effect.

So why would this work? Well more sunlight is always better. In state, in house fraud monitoring can never be as good as the collective wisdom of interested academics, researchers, other clinician and providers from all over the country. People who could look at these bills, make sense of them, and know this particular provider is three, four, five standard deviations for the mean from their practice in their area for their area of speciality. And taxpayers have a right to know how their dollars are being spent. Fraudsters may know how to beat the locals but there is no way they can beat the collective wisdom of everyone who is involved.

I see my time is up but I will, one more slide to run

through. I would take you, when you get back to the office, goggle Gold Court Challenge. This is an example of this concept in practice, not in healthcare but in another industry. We can talk about it in the Q&A where they posted their data online and just had an absolutely stunning return far beyond the wildest positive suggestions.

So who should support this concept? Well, the modesty firmly in check, every honest provider of Medicaid services, every Medicaid patient advocacy group, every taxpayer, and every elected official who has an interest in eliminating waste, fraud, and abuse. One cannot solve a problem with the same thinking that created it. Thank you very much.

ED HOWARD, J.D.: Thank you, Jim. Sounds like a unanimous consent request to me. [Laughter] You know we tried very hard at the Alliance for Health Reform to make this a forum in which people don't have to worry about being blind sided by partisanship. Our next speaker Ray Scheppach of the National Governor's Association has been doing that kind of delicate balancing act for the last 25 years. As Executor Director of the NGA, Ray has a new chairman, one from a different party from his previous chairman, what is it every year?

RAY SCHEPPACH, PH.D.: Every year.

ED HOWARD, J.D.: Every year. It helps that he is a

respected economist. Very comfortable saying on the one hand X and on the other hand Y. [Laughter] But he is here to give us some one handed remarks about Medicaid and the economy. We are very pleased to have you Ray.

RAY SCHEPPACH, PH.D.: Thank you, Ed. Just wanted to follow-up on Jim's comments a little bit and if we see the federal contribution in growth rate to Medicaid jump next year it's probably that Dennis Smith did not in fact go write that book but he is out working for states. [Laughter]

I would like cover four items real quickly. One what is the current fiscal condition of state. Second, why will it worsen over the next year to 15 months? Three, why does the state impact lag the overall economy? And what are some potential policy responses.

First end of year balances have been coming down quite dramatically. As of 2006, there were over 11—percent. As of about four or five months ago, they were down to six percent. I suspect they are in the four to five percent range right now.

Second of all spending has been coming down. Average growth rates in state budgets over the long run is about six and a half percent. Spending for 2008 in governor's budgets is about 4.6—percent. We did a very quick estimated based on a survey of states about two weeks ago. What is the current

short fall? We've got 18 states with about 14 billion short falls for 2008. Most states are on a July to July. And we got another 18 states that have short falls of about 32 billion for 2009. So it's beginning to increase.

Currently six or seven states I think are in recession. California, Florida, Arizona, Nevada, Michigan, perhaps Minnesota those that are the states that rode the housing bubble up and they are riding it back down. WE do have a small group of farm and energy states that are doing fine. The rest in the middle I think have now realized that they are in fact on the way down.

Our best estimate on the sales tax revenue growth which normally again grows six and a half percent is down in the one to two percent range now and a number of states seeing negative. We always see the downturn in sales taxes before we see it in income taxes, which normally track a point.

There is another impact out there that most people aren't talking about much and that's the local government impact which I would argue is going to be quite significant particularly in these states because property tax revenues are going to go down quite dramatically. Although that's going to lag and the place that local government comes is actually to states for bail out so this I think will affect

the elongate of this downturn.

Based on those estimates that I gave you in terms of the fiscal condition I would argue that within the six months we will probably have 35 to 40 states with short falls. The reason for that is it does in fact lag. If you look at the last two recessions, the one in 1991, we had 28 states cut budgets in the year that the recession ended. The following year we had 35 states cut budget. In 2001, the year it ended we had 16 states cut budgets. For the next two years, we had 37 states cut budgets.

Now you ask the reason why does that happen? Essentially, because you get a reduction in the sales tax early. You don't really begin to lose the income taxes until you get unemployment, which is normally consequential or even lags depending upon the recession. Then the Medicaid growth rate normally comes in towards the end of that downturn. So that is the normal cycle of it and that's why the major impact on states is not consequential with the year that the recession is terminated but it's the subsequent two years. Although economists have a fancy definition of recession, normally they only last nine, ten, maybe 12 months. But the impact on states can normally be a two to two and a half to three year period.

One of the major reasons for assisting states is that

state activity is post cyclical because of the balanced budget requirements of the 49 out of 50, Vermont is the only one who doesn't have a requirement but they tend to be fairly fiscal year conservative anyway. But to meet the balance budget requirements they have to either cut spending or raise revenues both of which are pro-cyclical meaning they make the downturn more severe and longer. And therefore giving state aide so that you don't have to make those cuts is normally considered a fairly positive counter cyclical approach. It's not just NJA that says this. If you look at CBO or if you look at Mark Zandy combi.com, they will argue that state fiscal, it may not be as good as highly targeted income rebates but it does trump most of the business types of deductions that are in the normal stimulus plan. So I wouldn't say its number one but it's clearly in that second category.

What we put on the table this last time was something similar to what we had enacted in 2003. It was a combination of increases of six billion in ETHMAP and six billion in bought brand. One of the major reasons we put the bought brand component on the table is that we have to remember that these sub-prime loans are going to continue to trigger over the next year and a half which means this situation even with a 30-day moratorium and so on is probably going to continue

to deteriorate. And we have a number of states that are actually out working with neighborhoods, counseling, working with lenders and so on trying to keep people in those particular homes and some additional money in bought grain and wheat we think actually measures a positive thing in terms of prevention from allowing this thing to deteriorate further.

This is very similar to what we had enacted in 2003, which is very good in that all the rules and everything have previously been worked on both the bought brand and the ETHMAP. The ETHMAP is very good because it can be done immediately and as soon as that's enacted, you don't have to wait for money to flow, governors automatically begin to change planning horizons and they won't make the cuts in the Medicaid and the other places that are needed to. So it's one of the few that is very, very fast. In some ways a lot faster, it's going to take us four months to get the checks out on rebates. ETHMAP goes in immediately so it's a fairly positive type of effect.

The only thing I would say in terms of the negative I would probably agree with John. The secret here is if we could make it more highly targeted it would help those individual states number one and number two it would be a more effective counter cyclical. In fact, I would probably

argue it might even trump rebates to individuals if you could target it on those states that in fact need it the most.

I will return my 37 seconds. [Laughter]

ED HOWARD, J.D.: Thanks very much Ray. Our final speaker is the very patient Barbara Edwards, the Director of Health Services at the American Public Human Services Association, which means that she is in charge of the National Association of State Medicaid Directors. She has a lot of practical and analytical experience with the Medicaid program having run the Ohio Medicaid program for eight years and helping other Medicaid programs, not just in her current role, but before that as an associate with one of the most respected firms doing Medicaid consulting work in the country, Health Management Associates. So she brings a variety of experience and expertise to us and we are very pleased to have you back Barbara.

BARBARA EDWARDS: Thank you very much. Actually, I'm not patient. I'm sitting here like Dennis; I'm taking notes like crazy from all these [laughter] really smart people on this panel. I really appreciate having the opportunity to share with you today sort of the down and dirty front line experience of what's its like running the Medicaid program when the economy goes soft. The reality is that many directors in the country have a lot more experience with this

right now than they are happy with having.

Just a few slides, the first is sort of the general, some of the numbers I think are most helpful for you to take away from what you have heard today. And you have heard some of these numbers already but I think it’s important. first of all Medicaid by the numbers 50 million covered lives, about half of those are children but 70—percent of the spending is being driven not by the children, not by the low income parents that are covered by the program but by the elderly and people of all ages who have chronic or disabling conditions.

So when you think about Medicaid it’s often, it’s easy to think working families and folks who get cash, assistance. The reality is the money in the program is being driven by people with disabling and chronic conditions including the elderly. And in fact, 40—percent of the spending in this program across the country is for people who already have Medicare health insurance. And that’s I wish people in this room would take a moment to think about particularly when as Dennis said Medicaid sometimes gets overlooked and maybe not attention paid inside the beltway. The fact is 40—percent of the spending is for people that are insured primarily through Medicare. And those two programs in fact are not aggressively engaged in finding more effective

and efficient ways to deliver services.

There are some activities but this is as huge overlooked area where I think there is potential for enormous real savings and better outcome for people in the program. So, 50 million covered lives most of the dollars are being spent on people with chronic and disabling conditions, 40—percent for people that have Medicare so they are not even uninsured by anybody's count.

Medicaid is a huge part of states' budgets, 20 to 24—percent depending upon the state. And because the cost of healthcare is growing faster than state revenues, it in fact takes a larger share of many state budgets on an ongoing basis. Medicaid in average the federal state split and this vary from state to state and from year to year, is about 60 cents federal dollar, 40 cents state dollar. It varies from 50/50 to much higher federal match rates. And that has some big implications for states as they face downturns as well.

The other thing I want to just mention to this audience is that the idea that Medicaid sort of started as a companion piece to welfare and cash assistance and some of the old forms of social services. the fact is today in almost every state the number of people who receive Medicaid health card who are also getting cash assistance is probably less than 25—percent of the total enrolled population. So again,

this is in fact a very different program than it was when it started. It is a health coverage plan and it is a major one in the country.

So, what happens when the economy slows? This is my very simple picture of what you have been hearing from all these very smart people up here. The economy slows, Medicaid is counter cyclical as people lose jobs or if they lose health coverage because their employer is cutting back on those services of a bad economy. More people become eligible for Medicaid. The demand grows at just the moment the state can least afford to pay for it. When Medicaid grows, it's such a big piece of the budget that it puts immediate pressure on state budgets and can be a part of what drives deficients for state budgets.

As you have heard, people say states don't have a choice. They have to balance the budget and they have to balance it in the fiscal year. They can't wait. They can't average it out over a few years when things are a little bit better. They have to balance it now, which means they need things they can do now that change the spending before the end of the year. There is not time to reform the program. There is not time to start a public process. There is not time to have a negotiation with CMS about some of the wonderful new things in the system.

And the fact is most states are already doing managed care. They have already taken advantage of many of the options for managing the program more effectively. That's what they budgeted for was that new reform system. So when the economy changes and the demand for Medicaid changes they still have a fiscal problem even if it is Arizona that's running a wonderful Medicaid program. So when states have those fiscal deficients the first thing they cut may not be the Medicaid program because there is that federal revenue that's associated with it. but eventually it's such a big piece of the budget, you have got to pay attention to it and make changes to the spending in that program, particularly if there has been as many states have experienced a long period of economic slowdown. In the last recession, where they cut everything else already and there is not much left if you don't start going into Medicaid.

The thing to keep in mind is that from the state's prospective to get a dollar savings in state general revenue funds you have to cut $2.40 out of the Medicaid program if you are a state with a 60—percent federal match. So the size of the program cuts you have to put in place to get the dollar of state savings out is much larger than what you save at the state level. Federal government also does some savings in that and maybe that's a good thing but it's a much bigger

impact to healthcare and to the program than in a program that was fully funded at the state level.

What happens from that is that there is basically a multiplier effect in terms of the impact, in terms of the lost revenue to the local providers, who are in many communities the largest employer sector. So you have sort of to get a little bit of savings at the state level a much bigger cut in Medicaid that has in turn a further slowdown impact on those local economies. So it is sort of a downward spiral. That's my very non-economist view of the world.

The federal impact on this kind of a cycle could can come take place in two places. One is if the federal revenue is further pulled back through federal policy action either because regulatory changes make federal dollars less available or because the ETHMAP gets reduced for example and there are some proposals on the table to do that. That can speed up this process of putting the state in a fiscal challenge causing the state to look at cuts, causing local economies to lose even more dollars and further increasing the challenge.

When states look at the idea of a stimulus basically what it is saying is the other way the federal policy could impact is to intervene between the fiscal problem and the Medicaid cut and hopefully prevent that cut, keep the

dollars, at least stabilize the program so that you don’t further reduce the spending in the healthcare sector. And by the way create more uninsured people and add more pressure in the system that way.

In case people sort of think because of this federal dollar that’s out there states don’t cut the Medicaid program the fact is they do. and in fact, the period, the experience that states had over the last recession and these are data that show state activity from fiscal year ’02 to fiscal year ’06 in terms of cost containment for Medicaid, show the kind of activities that every state in the country implemented and sometimes year after year during that downward cycle.

As Dennis mentioned earlier, the things you can do to produce a short-term cut in spending is to reduce what you pay to providers. It will reduce the number of people that you ensure or reduce the benefits that you buy. The other kind of reforms whether it is for transformation, whether it’s to fundamentally redesign the program, put even more people in managed care. Those are very good ideas. In some cases, they don’t happen within the same fiscal year in which you start work. So to do something to meet that fiscal challenge states have to do sometimes give up these federal dollars in order to save the state dollars and they do that through rate cuts, restricted coverage and restricting the

benefits.

So for Medicaid directors, these are times of high stress. It is high stress on the programs and frankly, the larger reforms in the program are more likely to occur when the economy is stable and people have the time and the resources to make some of the investments that you need to make to support strong reform and transformation.

Thank you.

ED HOWARD, J.D.: Great, thank you very much Barbara. We've had, I took a lot of notes myself and learned a lot. Now you get a chance to join the conversation. Barbara's slides will be on our website as early as close of business today so you can download those if you want to at allhealth.org or kaisernetwork.org.

Ray mentioned an article by an economist named Zandy. I think you will find those in your materials on the website as well. and I neglected to mentioned by the way just in passing that we would very much like you to fill out those blue evaluation forms that are in your packets so that we can improve these programs in the future.

We have microphones to which already we have someone repaired. We have the green question cards that you can fill out and hold up and someone will bring it forward. So let's get started. Yes, would you identify yourself?

JOHN GREEN: Yes, My name is John Green from the National Association of Health Underwriters. Some questions for Ray. I read in the *Washington Post* recently about my state of Maryland that they discussed how in good times they expand populations and they spend the money as fast as they can get it because it seems that contingents want them to. So when there is a downturn they don't have any money for bad times. And I'm wondering, I remember attending one of these the last time we had this problem and I know I appreciate Barbara's comments about we don't have time for that but going forward what about having a rainy day fund for Medicaid and putting money aside for when there are bad times instead of you know depending on the federal government for bail out.

RAY SCHEPPACH, PH.D.: Well I think, I don't think states have done rainy day funds for a particular program but virtually every state has a rainy day fund. They access them differently. Sometimes they can be accessed by the governor, sometimes you need legislative approval, sometimes it's a hybrid. You can access it up to a certain amount. But the last two downturns states had between 11 and 12—percent rainy day funds of spending. And so I think they have been fairly good about trying to build those in good times.

They have to, you know governors have to deal with legislatures too and when you start getting rainy day fund

above ten, 11, and 12—percent you do get a lot of pressure from the legislation to in fact spend good. But I think they are fairly responsible on it. The last downturn we had in 2001 from a state prospective was the worse downturn since the Second World War. I mean revenues went negative by about seven and a half percent for a couple of quarters. That almost never happens. And as of 2006 they had 11 and 12—percent surpluses again. Now it's been eroding as the economy has been slowing. But I think they have been pretty responsible.

SUE ALLEN GALBERT: Sue Allen Galbert with Anchor, an easy reg question for you Dennis because it's not one of the ones in the current topic of discussion. Implementation, I mean the final reg of projections for coming out on for lack of another word, the private provider tax reg and then just as a general comment. You know it's always interesting to me when so much emphasis is placed on the cost of Medicaid, its rising growth rate and spending when in fact the conversation ought to be around blaming you all. The conversation ought to be around in general the rising cost of healthcare and how much of every individual's budget or family or state in other state operated programs, how much of that is affected by the cost of healthcare in general. Thanks Dennis.

DENNIS SMITH: Your question is when will the final

reg come out? Soon. [Laughter] Definitive.

DIANE ROWLAND, Sc.D.: We have two questions here that really relate to the concept of state forecasting of Medicaid expenditures. One directed Barbara at you or at Ray for how do states forecast Medicaid expenditures. Are they comfortable with the tools they have to do that? And Dennis does CMS provide any assistance to the states in helping them forecast Medicaid expenditures.

BARBARA EDWARDS: Well I will take a stab at that. I think in fact many states feel pretty comfortable about the ability to forecast Medicaid except when something changes dramatically. I know in Ohio's experience that it was a pretty sophisticated process. It wasn't someone just taking last years spending and say oh, I think that, let's rise up by six percent. Projections were done basically at a rate cell level, you know at a category level. There were many models run and there as a pretty sophisticated forecasting process, that was used. The reality is in any forecasting you are having to make assumptions. You have to make many assumptions around the Medicaid forecasting models. And there are the things that make the biggest difference if you get a little bit wrong. Caseload is one of the biggest ones. And that really has triggered then by whether or not you got the economic forecast correctly pegged. And lots of people have

trouble with that particularly at predicting exactly when the bubble is going to burst, exactly when something is going to change that's going to dramatically increase or decrease. Obviously, the decrease is much more a problem from a budgeting prospective if the economy drops. So I think states and states probably vary in this but states are pretty sophisticated around this. It's such a big part of the budget. It's not as though they are cavalier about it but this really gets down to how well anybody is able to truly predict the economic future of any state and if we were all better in that we would probably all be richer than we are.

DENNIS SMITH: Generally, we do not because the states are, have the information and have it on a much more real time basis than we do. Forecasting back in Virginia for example I mean we used very specific things that Virginia knew but HICFA at the time would not have known. So, but states do use you know national health expenditures. So they use resources in terms of what is generally available but for their own forecast they would be direct than that.

We do look at the draws again Medicaid on a quarterly basis when states are drawing down. And if there are sort of big swings one way or another, we certainly contact the state trying to figure out why. Here and there, you get into a situation where you start seeing some things that we would

contact states. They themselves may or may not have a good explanation as to really what's behind their numbers but generally, they are so much closer than we are, and it's almost exclusively a state.

BOB HALL: I'm Bob Hall with the American Academy of Pediatrics. I want to thank the Alliance so much for having this meeting on Medicaid. We love Medicaid. It works very well for children and actually, there are problems of course. One of those problems is that from the providers prospective you know the pediatricians prospective, on average, we get paid about 70—percent or a little lower than Medicare, under the Medicaid and SCHIP programs. We try to stretch that as far as we can in terms of providing medical homes to children but we are very concerned about what's going to be happening this year coming up. As you put on one of the slides, every single state cut provider payments as result of decreases in Medicaid funding and resources.

One of the things that was in a couple of the bills last year that didn't make it through was an idea of a Medicaid Med pack. Essentially, I think it was called the Cape and the Champ Act. And it was also in the original Senate bill that looked at this. I know there was a discussion of this in front of the Medicaid Commission two years ago. And I'm wondering what the panelists feels about

this. Or what the panelists feel about this. We have been in favor of this for a long time. Certainly folks in this room get twice yearly reports on the Medicaid program about where savings could be achieved you know where funding should be increased, etc. But I think there has always been this sort of state federal dance that goes on in the Medicaid program that's very different than the Medicare programs.

So in the interest of full disclosure and the interest of sunlight what do folks think about that?

DENNIS SMITH: Well, I guess everybody is looking down here. [Laughter] I don't think that would be a particularly effective thing to do. Federal dollars follow state dollars. The states make the decision. It is a decision that is made in state capitols and the men and women who get elected to make those decisions about reimbursement rates for this provider or that provider, I think at the national level, we would just, it would be you know sort of a centipede tripping over all of its legs. To relate what's going on at the national level to what a specific state, I just don't think would be particularly productive.

ED HOWARD, J.D.: Anybody else? Jim?

JAMES FROGUE: Just as a broad comment, kids are cheap. And there is a lot of kids and women and children are 60, 70, 80—percent people in Medicaid but they are very

cheap. Expensive as Barbara said long-term care, people with multiple chronic conditions, the same people year in and year out and fraud. Barb also made the correct observation that most states when they look at what to do about Medicaid cut people, cut benefit rates, or cut rates or cut benefits. Rates, benefits, and people.

What about going after fraud? I mean if fraud were attacked in a meaningful way and it were as much as it appears to be there would be a lot more money left over for things specifically like pediatrics, not to mention many other areas.

JOHN HOLAHAN, Ph.D.: Yeah, I think that minimum standards for provider payments particularly doctors and hospitals is a good idea. I think that is a, I would support that and have written that in different places. I think that the big issue because this has come up before in Medicaid costs is not in those populations, it is really in the disabled and elderly and the population to share between Medicaid and Medicare. There is just an enormous amount of money spent on those populations. And for some, for people at the tail of the spending distribution an incredibly high amount and I think we can just do a much better job of managing the care that those people get and save money. That, just to look any place else given the history of Medicaid and

how states have fought of cut provider payment rates that would benefit issues and things like that, it just is foolish. That's where the money is and that's where the emphasis I think has to be.

BARBARA EDWARDS: You know just in turn, a couple of comments. One is that actually the interesting thing is states probably pay pediatrics or providers better than they pay most other community based providers. So one of the challenges for states and I think there are clearly states that are taking a hard look at how they could make a stronger investment in particularly primary care and community based care in terms of reimbursement. The challenge of course is where does the dollar come from that brings you to that standard. It's not free. And if you believe that the dollars are in the system you got to figure out how to get it out before you can reinvest it. So the challenge here is sort of the chicken and the egg. Where do you start in this because it isn't free to do that and you got to either pull the money from someplace else in the system which is easier said than done, or you have to find more money which is even harder. So I think that what the idea of a more efficient and effective system if it would free up those dollars, the challenge often is providers will argue will you have to give me more money first before I'm going to be able to produce that more

efficient and effective system. So you got this problem of how do you get started on that.

I think with the issue of can you find more money from fraud, frankly I think states believe the stronger place to place the investment is to prevent the bad dollar from going out in the first place because the pay and chase actually doesn't get you much back by the time you go through the legal system to prove fraud and then try to find a dollar left in that provider's pocket to get back, it's not fast. It's very complicated. I think you are finding states making much heavier investments in finding more effective up front editing and screens and cost sharing. Some of the changes Congress made recently to try to make it, to require the other third party payers collaborate more effectively with Medicaid around third party coverage. Those kinds of things can be very effective at preventing the dollar from going out in the first place. And I think that's where a lot more energy needs to be placed so that those dollars are more immediately available to invest in more effective places.

BRANDON CONNOR: I'm Brandon Connor. I'm from the Men's Health Network. I just wanted to pick up on something that you were talking about John in terms of the number of people who are going to need to access Medicaid if there is a downturn. Do you have any information on what those people

will look at in terms of gender, race, ethnicity and other sort of demographic breakdowns like that?

JOHN HOLAHAN, Ph.D.: [Inaudible 1:10:40] with Bone Garrett to see whether that can be pulled out of the data that he used. I suspect it can but I'm not sure.

GAIL HAROLD: I am State Representative, Gail Harold, chairman of the Health Quality Committee in the state of Florida. I deal with this problem every single day. Florida has 2.2 million people on Medicaid. We have had increasing Medicaid costs to the sum of increases of 16 to 17—percent per year. We recently did some Medicaid reform and had a huge bill two years ago dealing with Medicaid reform. And I believe that this has enabled us to stabilize our budgets. And I would ask that as the federal government looks at whether it's ETHMAP or where you go with this that you also look at again under the DRA or other legislation to look at things to free up states to be more creative, more inventive in how we use those Medicaid dollars and don't tie our hands in strict allocations in thoughts of money. Let us do those creative things. The incentive side of things is so much more effective in dealing with fraud for instance, Jim. We have put in place 3000 PDAs to our highest prescribing Medicaid providers. What that has done is has reduced our spend, our Medicaid prescription spend significantly by 17—percent

because not only are we tracking fraud, eliminating those duplications, and doctor shopping that went on when things like controlled substances and OxyContin things of that sort, but also it gave us the ability to bounce those medications off our PDL. So that we then incentivize the physicians to use the PDL, to choose the correct prescription. It also gave us the ability to prevent adverse reactions and adverse incidents and duplications and interactions of medications. So flexibility gives states the ability to help deal with this problem. And I would really suggest that that be the direction we look also.

ED HOWARD, J.D.: May I just ask do you have enough experience to have a sense of which of the tools you put in place got you the most bang for the buck.

GAIL HAROLD: Certainly, the PDA program gave us a huge, huge return on investment. For a minimal amount of money we could place 3000 PDAs, we increased, we did pilot program with a thousand to start with and every year we have added a thousand since we start doing that. And it has really created, it really has assisted us in our drug spend, tremendously.

Also, different things that we are doing through a Medicaid reform program in two different areas of the state has really enabled us through a variety of mechanisms to

really stabilize our costs. And we are not seeing the tremendous increases. We haven't seen reductions and that's not our goal. Our goal is simply to do not have our increases at the rate that we were. We want to make sure that our patients get the very best care possible but that every dollar is spent as carefully as possible.

ED HOWARD, J.D.: Reaction from some of the folks.

DENNIS SMITH: May I –

ED HOWARD, J.D.: Yes Dennis?

DENNIS SMITH: Yes, please. And maybe I can say this Barb doesn't have to. One of the places I would urge states not to look for savings is on the administrative side of their program. States need to invest more in well-qualified staff who are able to write an RFP for managed care, who can write contracts, who can do the over sight, etc. Again having come from a state I know that sort of the easy quick places that you look are we will put a freeze over here. We do an across the board reduction administrative costs. States need to invest in their administration of the program. Part of that again is where we see ourselves today, again sort of in the good times or in the better times, for state budgets. That was the time to do the planning. That was the time to do the investment. That was the time to I mean again it is difficult to say now we want to do something to on cost

share. Well if your Medicaid management information system can't handle it, you have maybe wanted to do a policy option but operational you can't support it. So that's, I would urge states to not look at cutting back on the expertise that they need to manage these programs. Again, these are 20 to 25— percent of states entire budgets. These are huge economic issues to the states. You need well-qualified people to be running these programs.

GAIL HAROLD: I would absolutely agree with you and I think going a step further with that I think we need to look at how we can really incentivize providers, incentivize new programs that deal, that have the outcomes and we need to look at outcomes and be outcome focused in reducing those costs and making the very best use of each dollar. And that is certainly one of them.

BRANDON CLARK: Hi, I'm Brandon Clark. I work with the Energy and Commerce Committee in the House. I have a two-part question. The first part is for Ray. I understand that the Deficient Reduction Act, the Medicaid reforms in that bill were largely based on unanimous recommendations of the NGA, the vast majority of those and that those were largely based on the state's experience from 2001 on economic downturn. Now that we maybe going into another economic downturn is it possible that you see more states taking up

some of these state plan options.

The second part of my question would be for Dennis. Since these are state plan options how quickly can CMS turn around an SPA from a state. So I know there were some discussion earlier about you know we might need to put more money into the ETHMAP because no other mechanism would be quickly implemented. So I was going to see how quickly that you guys could turn around an SBA.

RAY SCHEPPACH, PH.D.: I would say yes. The DRA we were the driving force on getting those particular changes. And it was very much as emesis within our organization. I would say that they were not necessarily a reflection of what they needed for downturn in all honesty. They were more longer one, good policies I suspect. But I do believe that you will see them increase dramatically over the next year because it is an option to save money so I think it will probably accelerate. They will probably stay as more permanent policies for those states that implement them.

DENNIS SMITH: In terms of how fast we are, generally we are pretty fast. Thinking of some of the benefit flexibilities that we did with states Idaho, West Virginia, those were pretty quick approvals relatively speaking. Again, a lot of it is how prepared is the state on their own to be able to put their state plan and mimic together. Certainly,

we are available to help states draft their state plan to accomplish what they want to do. So I don't want the, we will certainly do our part to assist states in technical assistance and quick turn around.

ED HOWARD, J.D.: Barbara?

BRANDON CLARK: Thank you very much.

BARBARA EDWARDS: I was just going to say I think Dennis made a good point that I think in Idaho, in West Virginia and some of those early states there was a quick turnaround but it had been a fairly lengthy process at the state level of gaining the level of consensus and political support to be able to support some of those changes. So it really does take, I mean it is, Dennis is right. When the times are better is the time to really get started on those kinds of activities.

DIANE ROWLAND, Sc.D.: This is a similar question for Dennis. In your statement, you indicated that the flexibility afforded to states through the Deficient Reduction Act could help state fiscal problems during the economic downturn. What flexibility are you specifically referring to and are you suggesting that this flexibility alone can mitigate states' economic concerns.

DENNIS SMITH: Well there are a number of different parts of the DRA. I think all of them working together can

have significant savings for the states and we have seen this on the long-term care side as Barb has mentioned. Again people with generally the long-term care side of the program people with disabilities who are sort of large cost drivers but children though I, again I think Jim mentioned earlier kids are cheap. Well that is generally the prospective and generally the idea but also even kids now the per capita, estimated per capita costs for 2009 for a child for a full year on Medicaid is now $2900 of federal and state combined.

I think a lot of the flexibilities on managed care, it is generally seen as an avenue that has been used by states and used successfully both to increase access, to improve quality of care, and to generate savings but as I mentioned earlier if you don't have the expertise to negotiate a good contract to protect the state then in the end it's not going to save you. again if you have created something that to where you are paying PMPs and yet you have craved out services that or don't have effective networks to where people are still ending up in the emergency room, still driving up fee for service costs then the policy was the right thing to do but it was, you didn't execute it very well.

People with home community based services, which the DRA makes it simpler for states to do. We have one state so

far that has done the 1995 state plan option. More states should be looking at that option in serving people in their own home. A quick one right off the top, on selective contracting. Again, an area where Jim mentioned places in fraud. You are doing selective contracting putting certain services out to bid, ancillary services, DME, transportation, etc. Those are all good places for states to be looked at to where you are using competition to drive healthcare savings.

But often times what we find in healthcare and it's not unique to Medicaid by any means again there is a lot of pressure. Sometimes you very much find you have come up with a cost saving idea and yet then other provider community, other contingences in the provider group says well that's a loss of revenue to me. So what are you going to do to make that up? So often times we do end up paying. We don't generate the savings because we haven't moved the money. It's we have moved part of the money and yet we are still propping up somebody else along the way.

It does take, I mean the idea of competition is that you are going to use the marketplace to drive for a better value but if then you turn around and give it back through another way, then no that's not going to save you money.

DIANE ROWLAND, Sc.D.: This question is given the difficulties in stabilizing state revenue, state budgets and

Medicaid spending over the long-term do you as a panel believe it is feasible to look to states to implement universal healthcare programs for their population or do we need to turn to national efforts.

What is one of the lessons of this experience for state health reforms?

BARBARA EDWARDS: You know I'm going to be brave and say something about this though I probably shouldn't. I think, its okay, that's a good point. I think states will continue to try. And I think they will continue to bring energy to this issue and we will learn from their experiences and we will learn from their successes and perhaps from their failures. I think we are kidding ourselves if we don't deal with the fact that most of the dollars in the healthcare system are controlled by federal policy, one way or another. The Medicare dollar, the Medicaid dollar, the funds for people who are in the public services, the armed services, retiree systems from the federal government, the Iressa provisions of the law. Most of the dollars in the healthcare system have federal policy constraining what the states can do around those dollars. So, I think we shouldn't kid ourselves that it can be done just by states. There has got to be supportive and compatible federal policy to, if you want to see states actually be able to move forward more

aggressively.

JOHN HOLAHAN, Ph.D.: I might comment on that area too. A lot of states are, the pendulum on healthcare form has swung back and forth between state leadership and federal leadership several times. Before President Clinton was elected, we had a lot of state experimentation and when it appeared that the federal government was going to do it, all of that stopped. Now we are in another period of acceleration. I think what has changed however from a gubernatorial standpoint is they no longer believe that the federal government is going to do it.

So regardless of what happens you are going to see a continuation of reform. That's broadly, it's around insurance reform. It's around health IT. It's around quality and so on. But the truth of the matter is there is not enough money in this system in most states. You will notice that the only states that have gone aggressively have been Massachusetts and Maine and Vermont, states that had originally a very high percentage coverage. But I think even Massachusetts now is struggling to fully implement this system because of the budget. We all know that California basically had to pull back because of their funding.

I would hope we would reach a point in all honesty where we would move together and it seems to me there is a

number of varies that the federal government needs to move. They need to move on standards of health IT. They need to move I would agree with Jim on certain standards with respect to quality. I would hope that they would move in terms of price transparency. They need to build that infrastructure for the system.

And second, they need to put some money for low-income people on the table. It can be tax cuts. It can be vouchers. It can give the state the ability to choose between doing a government program or doing a private program. But I think we need to reach a point where we move together. If our government needs to move on the infrastructure, I think they need to have states have a lot of flexibility to move forward then. And I'm fine with the federal government coming around and creating uniformity across states after the fact where in fact we need it.

I think one of the errors that we often make is we try to create uniformity on the front end of that. But what's happening in the states in my mind is both supportive of national reform and could be become an obstacle to national reform. It's supportive because I think states have moved forward and they have shown the way in all the variables and that's a very positive type of thing. But I think some of them are also a little bit reluctant to give up now that they

have progressed on reform because the federal government would end up preempting them across the board and I think we have to look at healthcare reform really through this federalism prism probably more so in this area than almost any other joint partnership that we have with the federal government.

JAMES FROGUE: I want to add quickly that one of the problems any state has with being first in creating a universal coverage option of some kind is that it would, it becomes very hard to sustain that pool. If you suddenly have a universal program in Oregon or California or Massachusetts or even south, Tennessee is very aggressive expansions in the ‘90s. There were serious problems with pooling and attracting some very high cost people and it only takes a small handful to make that pool unsustainable. And I think you saw a lot of that.

But I think Ray touched on something that’s exactly right which is a lot of states are doing a lot of good things. A lot of states are doing a lot of bad things. A lot of what we try and do at the Center for Health Transformation is work with states to talk about things that are working in other states. We try and be somewhat positive in a subject where there is an awful lot of negativity and pessimism. There are states that are doing very good things. There are

states like Arizona that have had a great Medicaid program in place for 30 years, 25 years. It's been working very well. Where reimbursement rates are high, providers are happy, patients are happy, rural access is good. There are models out there that are successful. So when you hear about those share them with the national Governor's Association or share them with us or share this with someone because there is not enough communication between states along things that are actually working and producing better health outcomes at lower costs.

And one final quick mention, I just think this is so, so, so important is always keep in mind how few people and how few providers are such a substantial part of the cost drivers. It is hard to emphasis enough how few people and few providers, it's, now these numbers vary by state of course, but it's roughly five percent of patients that are 50—percent of the cost. If you look at the data at a very micro level, the county level, the zip code level. You can find providers that are way, way, way out to the right end of the bell curve on the charges they send to the states. And you know, if you want to look down to the people level; and by the way, I should say, with always the strictest guidelines for patient privacy, but you can find patients that are in the emergency room 200 times a year. That could be much better served and

much healthier if they had more care coordination.

So instead of focusing on cutting reimbursement rates to all pediatricians for example states can do a much better job as aggressively going after providers that maybe doing things they shouldn't be doing or helping patients who are not getting good coordinated care because they are showing up in emergency rooms all the time with getting the right care at the right time so they are healthier and everyone saves money.

ED HOWARD, J.D.: We have only a couple of minutes so Diane has got a bunch of questions on cards. Let me just take a moment to suggest that you use part of your attention over these last five minutes to fill out your little evaluation form. Yes, Diane.

DIANE ROWLAND, Sc.D.: And we certainly couldn't have this forum come to an end without the questions that have been posed by many to Dennis, to Ray, and to Barbara about the impact of the recent regulations put out by the administration with regard to Medicaid and SCHIP and their impact on states' ability to be able to respond to the economic downturn. And as the economy softens, shouldn't one revisit these regs is one question. And another is shouldn't there be a moratorium as we look at counter cyclical relief for states. So you can answer it Dennis, Ray, Barbara; you

are the three online for this question.

DENNIS SMITH: Let ladies go first.

[Laughter]

BARBARA EDWARDS: You know my answer to this.

DENNIS SMITH: Maybe I should just go ahead and jump in. or Ray did you want to say something first.

RAY SCHEPPACH, PH.D.: I'll go after you Dennis.

[Laughter]

DENNIS SMITH: Well again, the regulations that we have promulgated in terms of cost rule. The cost rule is a rule that is designed to protect providers. In the California Financing Waiver, revenues to hospitals went up by 12— percent. We are looking at the situation in New York now to where New York City now wants money back from the Health and Hospital Corporation, money that we insisted should go to the provider and stay with them. So we think those are good things for the providers. If you have delivered a Medicaid service to a Medicaid recipient, you should get paid for it. And it should not be your obligation as a provider to pay the state or local government's share of the cost of the Medicaid program.

Some of these rules do go about to what is the partnership. Is the partnership in Medicaid intact or not? and if you can't provider tax that was brought up earlier, it

should, it is a unique situation I would think to when someone steps forward and says please tax me, you have to sort of wonder what's going on when somebody says please tax me that's what we have seen in the provider tax situation of how then dollars get moved around in such a way that I think is not good for the Medicaid program.

In terms of other rules that we have, so the cost rule embodies policies that the GAO has been recommending since 1994. So, when people say well lets put it off a little longer, I think there comes a point in time we really do need to get these in place for the good of the program because otherwise this tug of war that goes on constantly between the states and the federal government is not really a good thing. I mean it is you know but we keep doing this and we need to find a way to resolve it.

In terms of the other regs targeted case management for example. In some respects and we know states are very concerned and contacting their delegation. In many respects, the impact of targeted case management was the new rules are less of an issue than whether the state was really abiding by the old rules. And where you know GAO audits that occurred before we even proposed the rule of where states were funding different other programs not related to Medicaid but using Medicaid dollars, their problem really was the old rules. But

they were and sometimes, I have to say frankly also, I mean I think we're obligated to step forward and say we see what's going on here. And we need to do something about it.

One of the common defenses of the states when you go into these audits is well the rules weren't clear. Well, okay, now we are trying to make certain the rules are clear and that's seems to be a problem too. So we are kind of stuck coming and going on that one.

In terms of the August 17 memo, again poor kids first. The two Medicaid and SCHIP were designed we feel very strongly that those low income children should not be left behind before a state gets enhanced match rate going to higher income levels. So we think it is the right thing to do for the integrity of the program. We are in contact with the states on how to implement the August 17. We believe more states will be in compliance with the 95—percent threshold than states are often given credit for. So, you know again, I think that we need to move forward on resolving these things otherwise you are just going to, we are just going to be in the same place just six months or 12 months or 18 months later. And that's not really what the program needs. The program needs this kind of stability so we put sort of the tugs of war behind us.

ED HOWARD, J.D.: Anybody else?

RAY SCHEPPACH, PH.D.: Yeah. I probably agree with Dennis's first comment is that there is a lot of tension and pushing between states and federal governments and we don't come to the table a 100—percent clean hands either. I think at times we push costs on federal government and then the federal government pushes back to us. And I think that unfortunately it would be better if we had a more trustful relationship so that we would move together on these things.

And I don't want to talk about good or bad but I will say that there is six or seven of these where the accumulative impact is probably about $13 billion over five years from ONB's standpoint. And many of our large states estimated significantly higher costs to the implementation of these. So, it's going to drain off a lot of people who are going to be working on this as opposed to other things they are going to have to do in the downturn. So, it's accumulative nature of these and the potential cost, which we think these are pretty significant problem. We also think that in some areas they may have over reached the intent of the legislation and so on.

And it's one of the reasons in all honesty when we did DRA, when we got unanimous agreement; one of our standards was all of the options that we advocated say both the federal government and state's money. There was nothing

that we put forward that essentially pushed more costs to the federal government so I think we need to get to a point that we are talking about in a more efficient program saving money for both levels of government.

ED HOWARD, J.D.: Okay, well, that sounds like a thoughtful last word to me Ray. Thank you very much. We have run out of time, but I think we have not run out of topic for discussion and I know that this is going to continue in a variety of forum over the next few months if not beyond.

I want to take this chance to thank both Diane personally and the Kaiser Family Foundation and its Commission on Medicaid and the Uninsured for participation and support and sponsorship of this event as well. I want to thank you for being an active part of this dialogue. I thought it was a very, very enlightening one. And I want to ask you to join me in thanking the panelists for making a very diverse and useful presentation.

[Applause]

[END RECORDING]