Medicaid and the Economy
Alliance for Health Reform and Kaiser Family Foundation
January 9, 2009

[START RECORDING]

ED HOWARD, J.D.: I want to welcome you. My name is Ed Howard with the Alliance for Health Reform. On behalf of our senatorial leadership, Susan Collins and Jay Rockefeller, our board of directors, welcome to this program on the interaction between Medicaid and our current economic slow down.

Our partner in today's program is the Kaiser Commission on Medicaid and the Uninsured, which is a project of the Kaiser Family Foundation, one of the most respected policy voices in reform debate and discussions of other policy issues involving health care. You will hear from Diane Rowland from the commission and the foundation in just a moment.

Medicaid is a counter cyclical program. I am married to a Harvard trained economist. I know what counter cyclical means, I guess I'm lucky. Simply put, when the economy goes down, the demand on the Medicaid program goes up. Throw in the fact that states are by and large required by their constitutions to balance their budgets and you have some real dissonance to deal with.

While state and federal spending on Medicaid should be going up to cope with the larger numbers of people needing help with their health care when they lose their jobs, governors and legislators are forced to reduce spending on Medicaid and everything else, particularly since Medicaid is such a large proportion of most states' budgets.

I should add that both Senator Rockefeller and Senator Collins have taken a special interest in this topic. During the last economic slow down in 2003, they were leaders in putting in place legislation giving states a temporary increase in the percentage of Medicaid costs covered by the federal government, I will use the dreaded acronym “FMAP” which you may hear a few times before we finish, to help states get past that rough patch and similar legislation as many of you know is under consideration right now, perhaps as part of the economic stimulus package that is the top priority of congress and of President Elect Obama.

Today we get a chance to look at that experience back in 2003 and 2004, see what is happening today in the states and what the consequences might be of federal action or inaction in this area. I particularly commend to you several new publications from Kaiser on different aspects of this problem. There are a couple of them in your packets. There is one that you should have picked up in the stack as you came in. If you didn't get them, I commend them to you. You really ought to get hold of them. They are up to date. They are accessible and they are a valuable source of information.

And that of course brings me back to the observation that we are cohosting today's briefing with the Kaiser Commission on Medicaid and the Uninsured. They have done a great deal of work on this issue beyond the new publications

that you have and here to represent the commission and the foundation and sharing moderator duties is one of the country's top policy analysts in the field of health. She is the executive vice president of the foundation, director of the commission, Diana Rowland. Diane?

DIANE ROWLAND, Sc.D: Thank you Ed and thank you all for being here. It is once again a time when we gather to talk about an economic down turn, a recession and its implications for health care for some of the lowest income Americans as well as for state economies and the ability of states to cope with it.

And perhaps most striking today we heard that the jobless rate has now risen to 7.2-percent with a loss of over 500,000 more jobs in December. So we know that family budgets are being strained, that health care and access to health care for many families is in jeopardy, both with their loss of insurance and with their diminished income to be able to pay for any care that they need.

So more and more folks, as Ed said, are turning to Medicaid just at a time when the state revenues are least able to cover the increasing costs. So the briefing that we have put forth today really will try and set up a discussion for you of where Medicaid fits in the economic down turn, how Medicaid can be part of an economic stimulus.

And I think to start it is important for us to remember what Medicaid is as a program and I know many of you may be newly joining us for these alliance briefings where we try and lay out the facts and engage with you in a discussion.

So, the first slide that we have is really what we call the kind of Medicaid overview and it reminds us of all the different roles that Medicaid plays today. Too often we think of the program mainly in terms of its role in providing health insurance coverage to children and some of their parents and indeed it does that.

Today it covers one in four of America's children for their health insurance coverage and with the complementary program SCHIP it is really the main provider of health care services to children under 200-percent of poverty, our low income population, but it also is a gap filler for the Medicare program helping low income Medicare beneficiaries with their premiums and cost sharing, also a time when the elderly and the people with disabilities need more assistance and turn to Medicaid for help as well as the only source of public assistance for long term care expenditures which are a major source of financial burden for many families with children with disabilities as well as the elderly and people with disabilities.

It is a primary factor in the way in which we pay for health care services in the U.S. and I will show you in a

moment how that works and also obviously the major source of federal assistance to the states in terms of helping them meet the health care needs of their population.

In terms of its role in the health care economy, when we look at Medicaid in the health care system, it now pays for about 16-percent of all health care services and supplies used for personal health care. So it is a major purchaser in the health care market, but also as a major payer supporting the health care work force, supporting health care expenditures, accounting for 17-percent of hospital care, 42-percent of nursing home care, and 8-percent of overall prescription drug purchases.

So when we think about cutting back Medicaid we are not just cutting back on eligibility in coverage for low income people who have Medicaid as their source of coverage, we are also reducing the income and the ability to pay for services in the health care sector more broadly.

But when we think about who Medicaid covers it is important to remember that while the face of the program may be low income children, they account for half of the beneficiaries, the larger bulk of expenditures this program spends its dollars on are for assistance to the elderly and people with disabilities so that when we look at expanding eligibility or improving coverage for the low income population

for children and their parents, they are not the main cost driver in terms of Medicaid expenditures.

Which finally brings us to a reality that we have to deal with, especially as more people turn to Medicaid eligibility and try and qualify for the program that the way eligibility standards have worked is that mostly eligibility is at higher income levels for low income children and at very low levels of eligibility for a threshold for those who are elderly and disabled and for working parents and in fact today unless a state can get a waiver from the federal government, childless adults no matter how poor are ineligible for the Medicaid program.

So in this economic down turn as more people turn to the Medicaid program there is broad access for children at income levels at 200-percent of poverty or sometimes higher which is about $40,000 for a family of four but very limited access for the adults who are losing their jobs and losing their coverage which is why we see renewed pressure on the program. With that, I will turn to Ed to begin the panel discussion.

ED HOWARD, J.D.: Thank you very much Diane. Good scene setting and we are going to lead off the discussion. Now let me just say we apologize for the acoustics in this room. It is a beautiful room but it is almost impossible to hear in so I ask each of our speakers to be as distinct as they

possibly can and when you get to the point of asking questions at the microphones, do the same thing.

Let me lead off today then with Robin Rudowitz who is a principal policy analyst for the Kaiser Commission where she has been doing and overseeing a lot of analysis on Medicaid and low income people's health care coverage for the last several years. She has been a senior manager at the Lewin Group. She has served stints both at CMS's office of legislation and at CBO and Robin is here to give us a grasp of the basics of the interaction between Medicaid and the economy. Robin thanks very much for being here.

ROBIN RUDOWITZ: Thanks Ed and Diane. I am going to start off exactly what Ed said with a brief overview of Medicaid and the economy. We all know in this room quite well that the current economic situation is quite severe. There were 44 states either faced or facing current budget shortfalls in fiscal year 2009 or 2010. This includes 30 states that had budget shortfalls as they were heading into their fiscal 2009 year of about $48 billion.

Those states and budget shortfalls had to be addressed but now there are 41 states facing midyear budget caps of about $42 billion and 38 states are already projecting budget shortfalls for fiscal 2010 that could total $145 billion. State revenues are falling short.

Unemployment is rising, as Diane mentioned, just as of this morning we heard that the unemployment rate is now 7.2-percent, 2.5 million jobs lost over the last year and over 500,000 in the last month. The situation is always particularly difficult for states, as Ed mentioned, because they need to balance their budgets annually and they must use their reserves or raise taxes or cut spending to meet those requirements.

Looking backwards, states are really just recovering from the last economic downturn that lasted from 2001 to 2004. During that time, Medicaid enrollment and spending growth peaked in 2002, at the same time that revenues dropped sharply. States all adopted an array of cost containment strategies to control Medicaid spending growth.

All states across the country implemented some provider rate cuts or freezes. All states also implemented actions to reign in spending on prescription drugs and fewer states also adopted policies to restrict benefits or cut eligibility at that time. To help states, congress did enact legislation to provide temporary fiscal relief.

Half of it was in the form of block grants to states and another half was in the form of an increased FMAP for states. All states received a 3-percent or about a 3-percent increase in the match rate that would increase the federal share of Medicaid costs. That lasted for 15 months from May

2003 to June 2004 on the conditions really that states maintain their eligibility levels for Medicaid.

That fiscal relief proved to be a successful strategy in helping states to both close Medicaid budget shortfalls and general fund shortfalls and really avoid deeper cuts for the Medicaid programs than otherwise would have taken place. One criticism of that relief was that it really came too late into the economic downturn after states had already made such significant program cuts.

In addition to providing health coverage, Medicaid and the CHIP program as well both serve as important economic engines in state economies. Funding from these programs supports jobs and incomes, both within the health care sector and across other sectors of the economy and states through the multiplier effect of that spending. Medicaid's economic impact is intensified because of the federal matching dollars that followed the program. The same is true for CHIP although there are smaller amounts of dollars in that program but the match rate is higher. So, it is intensified even further.

On one hand, when states spend money on these programs they receive additional dollars from the federal government. On the other hand when they cut spending for these programs they lose federal matching dollars. Just as an example, a state with a 60-percent match rate really needs to cut total Medicaid spending by $2.40 to save just $1 in state Medicaid

funding and cutting these programs during an economic downturn really exacerbates and can worsen the economic situation for states.

When we conducted our annual Medicaid budget survey over the summer, just as states were starting their fiscal year 2009, they were already anticipating effects of the economic downturn. They projected that Medicaid spending and enrollment growth was projected to increase. When state legislators finalized their budgets for 2009, they authorized spending growth at 5.8-percent on average, higher than 2008. Even at that time, however, most Medicaid directors, two out of three of them, said they anticipated that level of appropriations was not going to be adequate for fiscal 2009.

We were able to get back in touch with the Medicaid directors in November and December and even a few months into the fiscal year it was clear that the economic downturn was affecting states across the country, although there was quite a bit of variation in the impact of the downturn.

Over half of the Medicaid directors, 30 states and the District of Columbia reported that spending and enrollment growth was already exceeding the levels that they had projected over the summer, in some cases by a lot, by a substantial margin. In many cases the states with the worst economic situation were seeing the largest enrollment increases.

There is one example I could point to in Nevada, they are experiencing some of the highest unemployment rates, large budget shortfalls, and substantial revenue declines. They have had to make three rounds of budget cuts to their program including Medicaid cuts, and they are at the same time facing double digit growth in their enrollment.

Many states are also facing the prospect of midyear cutbacks in fiscal 2009 and they are expecting that the program, the issues could be worse in 2010. Directors are really finding it difficult to identify options, especially after they were so aggressive in adopting cost control measures in the last economic downturn.

A lot of what we call the low hanging fruit in terms of just getting efficiencies out of the program have already been adopted and new cuts may really hit the core of programs. Medicaid directors are really thinking that the priority for congress in action is to adopt some type of enhanced Medicaid FMAP as well as the reauthorization of the CHIP program and withdrawal of some of the federal Medicaid regulations that could shift additional costs to the states.

Research shows us that for every one percentage point increase in the unemployment rate, employer coverage declines and Medicaid and CHIP roles increase by about a million people and the uninsured increases by about 1.1 million so we know if the unemployment rate went from 4.9-percent last December to

7.2-percent, we would expect to see an additional 2.5 million uninsured people.

These increases result in additional Medicaid spending at the state level as well as additional pressures to fund uncompensated care costs. At the same time, unemployment increases result in state revenue losses, which puts pressure to cut program spending across the board and including Medicaid.

We also recently conducted focus groups with families in five different cities across the country and we found that families are really being hard hit by the economy. Individuals with seemingly secure jobs were laid off and despite aggressive attempts have been unable to find new jobs. Families are really struggling to pay their rent or their mortgage to buy groceries, pay utilities and of course health care.

Individuals lost their jobs and their employer health coverage and they really can't afford to purchase the COBRA that they are offered and some don't even qualify for COBRA and certainly cannot afford other non group coverage. Those receiving unemployment benefits often were disqualified for Medicaid coverage because of the value of those benefits.

As a result, many are uninsured and are not getting the health care that they need and in many cases this has serious consequences. Individuals aren't getting insulin, hypertension medication, asthma meds, etc, so with no other alternative,

many are really turning to public assistance for the first time. Those who enroll in Medicaid have had a lot of success in getting critical access to care, particularly for children. However, better outreach and easier application processes and broader coverage options for adults would really help families that are in need.

Congress is currently considering and debating the components of a fiscal stimulus bill. Some of the options to help bolster Medicaid at this time of really increased need include certainly direct funding support for the Medicaid program.

There has been a lot of discussion and debate about the enhanced FMAP and I think there are still ongoing discussions about how much the level of that assistance, how long it should last, how that funding is going to be distributed across the states, and the conditions that states will need to meet to receive that funding.

Some other options to help bolster the program in terms of financing would be to shift some expenses, some Medicare expenses, to the federal government and again to resend those regulations that might shift additional costs to the states. I think states are also anxious for the reauthorization of the CHIP program which would bring stable and predictable financing as well as additional dollars to support children's coverage.

To help those in need it would also be helpful for policy makers to look at ways to improve eligibility and to simplify outreach and along those same lines to mitigate those burdens that are associated with the citizenship and identity documentation rules that were imposed by the DRA. Finally, policy makers are looking at expansions to Medicaid to help additional populations that are hit by the recession.

ED HOWARD, J.D.: Thank you very much, Robin. With that as a very fine background, now we are going to hear from several folks who have first hand experience with Medicaid and the people it serves in these difficult times and we are going to start with David Parrella who runs the Medicaid program in Connecticut, more formally he is the director of Medical Care Assistance in the state's department of social services.

He has twice chaired the National Association of Medicaid Directors and has more than two decades of service in state government and if I only hand him the clicker he will be able to move his slides.

DAVID PARRELLA: Actually I don't have any slides today. We are going to do this old school. Good afternoon, everybody. As the person who is currently the longest serving Medicaid director in the country, I come to you today with a perspective that has been shaped by the trials of earlier recessions and their economic impact on Medicaid, going back into the 1980s.

There are certainly similarities to previous recessions. Connecticut, my state, is in many ways as much a part of the tri-state area around New York City as it is part of New England. Like New York and New Jersey, close to 30-percent of the revenue that goes to our general fund is generated by income and capital gains. It is derived from activity on Wall Street.

When the street is doing well, we do well. In three out of the last four years, Connecticut enjoyed record budget surpluses driven by a bull market on Wall Street but just as in 2001 when the World Trade Center came down, these revenues have not tapered off, they have stopped. No state budget with the ongoing obligations for health care, education, and public safety can adjust that quickly to such a massive disruption in an economic sector that accounts for such a significant portion of its revenue base.

That is why now as in 2001 we are facing record deficits larger than 2001 on the order of $6.5 billion for the coming biennium. That may seem small in comparison to the prodigious numbers coming out of California and New York, but that is close to 20-percent of our total general fund and Medicaid alone is going to be expected to make up $1 billion of that but that having been said there is something about this recession that feels dramatically different from downturns that preceded it.

Yes, it is similar to the others in that Medicaid and food stamp caseloads are rising dramatically, just when revenues to support those programs are declining. The 6-percent increase of Medicaid caseload we have experienced in the past 12 months is probably just the harbinger of things to come.

But what makes this seem so different is that the bad news came so suddenly after a long period of economic growth that spurred our state, like many states, to seriously contemplate measures to close the final gaps of health care coverage.

We started from a very advantageous position. In 2007, only 9-percent of our residents were uninsured and we had not experienced a decline in commercial coverage that has been so well documented in other states.

Following the 2007 session of the general assembly, Governor Rell launched her Charter Oak Program which now provides state subsidized coverage to 4,000 previously uninsured single adults with premium assistance up to 300-percent of the federal poverty. We expanded Medicaid coverage for the parents of children covered under our HUSKY Program with incomes up to 185-percent of poverty and pregnant women up to 250-percent of poverty.

Realizing that coverage isn't enough if you don't have access, we increased provider rates for hospitals, dentists,

and doctors. We shifted our delivery model for behavioral health and dental care from at risk administration to non risk contracting to increase utilization. We carved pharmacy out of managed care to maintain one consistent preferred drug list across all our programs and we rebid all our managed care contracts with strict guidelines for transparency.

We soon will implement a primary care case management pilot to see if that further enhances the practice of a medical home model for primary care. All these measures were undertaken as part of a rising tide of expectation for access and for quality and now this. In my state, health policy enthusiasts can scarcely acknowledge that many of the gains we have achieved over the past few years will be difficult if not impossible to maintain without a renewed emphasis on cost reduction.

Many of us who question the wisdom of the cost sharing and benefit package options enacted as part of the deficit reduction act may be forced to find ourselves implementing them as an alternative to outright reductions in Medicaid eligibility. Groups that pay premiums now such as the households with children enrolled in our SCHIP program can probably look forward to much higher premiums in the future.

What can the federal government do to help out not just Connecticut but all the states? There is short term and long term answers. The national association of state medicaid

directors has identified an agenda for the first 30 days and for the months that follow that could address some of the immediate and longer term impacts of the recession.

In the short term, everyone acknowledges step one would be to provide immediate financial relief to the states in the form of enhanced Medicaid match rates. I would add that enhanced rate needs to be sustained for a period of 24 months as Medicaid lags recovery in the rest of the economy.

Number two, a reauthorization of the SCHIP program with adequate funding to address the needs of the states that are chronically under funded and as part of that the repeal of the August 17th letter that imposed limits on the flexibility of the states to use their SCHIP funds to cover children with incomes above 200-percent. States should also be allowed to use funds to purchase family coverage which would include adults.

Easing of the documentation for citizenship requirements that were imposed on the DRA, these requirements particularly now during our hardship, are actually keeping eligible Americans off the Medicaid roles and in some cases forcing states to state fund their care when federal match should rightly be available.

Suspend the collection of clawback from the states to fund Medicare Part D. Medicare Part D was unique in my experience where states were asked to pay for the expansion of

a Medicare benefit that rightly should have been part of the Medicare benefit all along.

In recent years, state contributions have not been adjusted to reflect savings realized in Medicare in the administration of the program which only makes contributions at the current level more galling. In order to incentivize states to aggressively pursue program integrity, CMS needs to rethink the whole perm process and immediately resend the requirement that states must refund the federal share of Medicaid within 60 days of an audit finding, regardless as to whether they have actually recovered the dollars. In most cases, they have not.

Immediately take action to repeal the six CMS regulations that are currently under moratorium until April 1st, 2009. These regulations include regulations on provider taxes, rehabilitative services, targeted case management, school based administration and transportation, public provider cost limits, and graduate medical education.

A substantial portion of the Medicaid budget that the states are struggling to sustain goes to provide care for persons who are already covered by another federal health care program, namely Medicaid. We need to look at ways that the federal government could start to buy out at least some of the health care obligations born by the states for the duel eligibles.

At a minimum that means a broader sharing of Medicare data on the duels with the states so that the states and the federal government can work together to contain costs and improve outcomes. A more ambitious goal would be to eliminate the 24 month waiting period for Medicare for SSI recipients.

I hope that the new administration will be open to restoring a productive state federal partnership. Medicaid has an important role to play not only in the financing of health care as an entitlement program but as part of a larger strategy for health reform. This cannot succeed in the atmosphere of distrust that has unfortunately characterized the relationship between CMS and the states during the recent past. Medicaid is boots on the ground in this recession and in a larger discussion of health care reform Medicaid will inevitably play a crucial role, whatever the outcome is. Thanks.

ED HOWARD, J.D.: Thanks very much, David. Next we are going to hear from Stan Rosenstein. For the last 22 years, Stan has worked with the California version of Medicaid called Medi-Cal, many of those years as its director.

David talked about the prodigious numbers in the California program, how about these, it covers seven million people and had a budget last year of $37 billion, prodigious indeed and Stan has been managing that for a lot longer than the average tenure of a Medicaid director which is something like 18 months.

So, he has been head of one of the largest health plans of any kind in this country and he has just joined health management associates, which is one of the most highly respected policy consulting firms in the country, so we are very pleased to be able to catch you on the East Coast. Stan?

STAN ROSENSTEIN: Good afternoon. I think I am in day four of my new career so it is very interesting having just left the state, I'm happy to be here. Let me talk a little bit about California's budget situation.

I think people compare California, if it was a country it would be the sixth largest economy in the world so obviously it's a big part of the economy and the world, a big part of the economy and the United States. California never came out of the last budget recession in terms of the state budget. A lot of states have seen a recovery and then has done very well.

California never got its budget balanced for a lot of reasons, which I won't belabor, but because of that California has been in an environment of cutting the budget now for about four years straight, where every year there is no real add-ons, it's a reduction in the budget. California was probably the leader in the collapse of the housing market. We saw it first.

You can drive through neighborhoods throughout California and see foreclosure signs everywhere. We are very much affected by the stock market. We are highly dependent on

income tax and if you are dependent on income tax, you are dependent on capital gains or lack of capital gains.

We are, I think, the third largest unemployment rate in the nation now and the only good segment of the economy, and that has started to show trouble, is health care. So, what we are talking about today is really protecting and enhancing the most vibrant part of the economy, at least in the state of California.

California has had continuing deficits and what has happened this year which is unprecedented is the state general fund revenue declined by nearly 15-percent or a little bit over $15 billion and that is between an expenditure estimate was done in July and today, 14.7-percent revenue decrease and work load just in the current year, the costs went up by $1.5 billion.

So you have got a situation where revenue is falling at levels that it has never fallen before as regular caseload has gone up this year and I will talk about what is happening next year. And that is a total general fund budget of about $104 billion so you can see that there is just a massive problem and the revenue is just not there and the expenditures continue to grow. California is in a fiscal emergency and California is at the point now where it could be issuing IOU's as early as next month.

This chart is very similar. I won't go into it with any great length. This copy of the Kaiser chart shows you about seven million people; again there are proponderous expenditures on the disabled. California Medicaid Program has already done a significant amount to be efficient. It is the second largest nationally in terms of dollars expended.

It is more than twice the size of the next largest program in New York. We had twice the size of enrollees in California and we don't spend as much as New York does. Nationally it is the lowest per capita in spending per enrollee and it covers the most optional benefits.

The state and federal tax payers get a great benefit from the Medicaid program in California and it has already done steps to save money and what is important to note is that when you look at the expenditures, the non-elderly adults with disabilities are 25-percent of the people but 61-percent of the expenditures. And then you can see the expenditures are very concentrated.

So, what this means is if you look at an environment where you have got to make major reductions in expenditures, and your expenditures are very concentrated, they are going to affect the most medically fragile and needy people. There is no way of escaping that in a Medicaid environment. If you are going to have to make major reductions, you have got to reduce

what you spend on vulnerable people. That is where the money is.

In the upcoming budget year, while the state's revenue is dramatically declining, the state Medicaid expenditures are anticipated to go up by slightly a billion dollar state general fund. That is on top of a $14 billion spending base so you can see that the increase just in the work load with no changes is very dramatic so the state is faced with dramatically dropping revenue and dramatically increasing the expenditure of Medicaid and I will just add on it's not just Medicaid it is the [inaudible] population is also growing, people on SSI are also growing.

There are never other factors. And then hospital inflation is also growing, so you have got this perfect storm of inability to cover your Medicaid budgets going on in California. California has already taken actions to reduce its provider rates by 10-percent July 1, litigation on that, but the rate reduction will continue either 5- or 1-percent being changed to March 1. There will be a lot of litigation on that.

The state has implemented new status reporting for children. It is estimated that will eventually take about 100,000 children off the Medicaid program in California, hopefully most of those children will be ineligible. We made changes to what we subsidized for Medicare beneficiaries for Part B payments. And that is the stuff that is already done.

In the pipeline for consideration is elimination of a number of optional benefits, most notably adult dental and optometry. Those are optional. Many states don't provide them. There are a lot of people who would argue that maintaining your mouth or your sight are not optional, but those are optional federally.

They are on the table because you can only cut what the federal government will allow you to cut. There is a reduction of coverage for working parents and two reductions, one is a reduction at income level, the second and more importantly is the reduction in what is called an underemployed parent.

For two parent families you have to be under employed or unemployed and that will make many two parent families ineligible for Medicaid in California. That affects eventually about half a million parents, initially 39,000 parents, a reduction of income level for coverage of seniors and people with disability, that affects about 60,000 disabled individuals, restrictions of coverage for immigrants and then further reductions and payments to the safety net providers, especially at a time when they are seeing increases in their cost.

This remark that the prior recession congress did and the president did provide economic relief, it saved the California Medicaid Program. Because of that relief, California did not have to eligibility cuts, kept the program

aligned and really allowed the state to bridge an economic crisis so I thank you very much.

ED HOWARD, J.D.: Thank you Stan. It is a sobering set of statistics. Now we turn to our final panelist who is Margaret Hulbert. She is the vice president for strategic resources and public policy for the United Way of greater Cincinnati.

She is responsible for developing these partnerships with other organizations to fund human services and community development and health for vulnerable populations in the Cincinnati area. She has seen close-up what happens to folks who gain access to the health care they need and what happens to those who don't. Margaret thanks very much for coming to share your story with us.

MARGARET HULBERT: Thank you and good afternoon. I work for the United Way of greater Cincinnati which is a fairly typical large United Way. We work in four counties in Southwestern Ohio and four counties in Northern Kentucky and work on public policy in two states. We invest about $50 million annually in health and human services, a broad array of health and human services for broad populations.

We do not historically focus on health advocacy. We do now and I want to tell you why. Historically we have focused on early care and education issues, family financial stability, and programs that serve youth. But what we have found is that

in all of our work and all of our investment, the underlying cause of so much of what is creating problems in all of those populations gets back to health and while historically what we have funded in health has essentially been diseases, lung cancer, and heart, we are now investing much more money in advocating for health care reform in the public sector.

It is inescapable to us that the relationship between access to health and other ways of being healthy, well, financially stable, they are tied inextricably and for us there are three reasons we are working on this issue. Number one, it is a health issue and we are concerned about the health of children and adults.

In this country, we spend more money on health care and we have worse health outcomes than almost any other developing nation. For us as a product of the business community and we are not only a funder but we are a fund raiser. And we are still very closely tied with the business community in this country, it is a key customer group of ours, health care costs are supplanting almost everything else for business as their number one concern, where it used to be access to market, taxation rates, any other number of things that businesses look at, the number one issue for them now is cost of health care.

We see businesses going out of businesses and we see businesses losing good employees because they can no longer provide health care. Nowadays our businesses are even

beginning to recognize that Medicaid and SCHIP are frequently the primary source of health care for their low wage workers.

We have some very unique projects now with our businesses, our supporting businesses where we are actually going into those businesses and enrolling children of fully employed parents in the SCHIP program because they are at a wage where they cannot afford to purchase health insurance for their children. Businesses are also increasingly interested in buy-in programs for Medicaid and for multi-payer health systems in which they are a partner.

The third reason we are interested in this and probably the biggest and the one I would like to speak to you about is for us, this is a major state budget issue. This not only affects health, it affects every other health and human services, every human service that a state does, it affects education, it affects higher education because of its relationship to state budgets.

You heard about this from Robin but this is a copy of the map provided by the Center of Budget and Policy Priorities that shows you that we now have 44 states that face budget shortfalls, that is a total of $350 billion. My two states, Kentucky and Ohio, are included in that, Ohio being one of the hardest hit.

Since enacting our '08-'09 biennial budget, which is $41 billion of general revenue funds over the biennium, we have

already cut $1.9, almost $2 billion of that $41 billion and those cuts will not be enough to get us through next June. Cuts include the laying off of 25-percent of our staff in the human services department, the closing of juvenile detention centers, slashing health and foster care programs, mental health programs, you name it.

In my state, typically on any given day they will receive 7,500 calls to the Department of Jobs and Family Services, which is the human services department. Last week they were averaging 80,000 calls per day. If you saw the news this morning, you know it is one of the states whose system crashed because it couldn't handle the volume of calls. With current projected revenues, Ohio will be short in the next two year budget an additional $4 billion, so our situation sounds a great deal like California's.

This gives you an idea of how Medicaid plays into the Ohio budget. It is the second largest amount of money in the Ohio budget. It is one of the biggest economic drivers. You have heard that already. But it is about more than health.

Again, we fund a variety of things from food security to senior services and what we are seeing now that almost every issue that we deal with, housing insecurity, debt, bankruptcy, food insecurity, children left unattended and unable to access child care, the more we look at each individual issue the more

we realize that underlying that in so many instances is a lack of health care coverage.

Now obviously the foreclosure problem in this country is a complex and multifaceted thing, but long before we saw the number of foreclosures we do now because of our current fiscal situation our largest driver of foreclosures in the state of Ohio were families who had lost health care coverage or who had major health care issues, and had to forego paying rent or mortgage because they had to pay for health care.

Why do we do health care advocacy now? There are numerous state and national studies that link health care and lack of health care to all the social ills that I just kind of enumerated but we didn't need the studies to tell us that. United Way nationally along with other partners has what we call our 211 system, that like 411 or 911 is a line that can be used by people who need to find systems for almost anything.

By the way, there is the calling for 211 Act, introduced by Senators Clinton and Burr and we do need cosponsors, so those of you who work for senators, please it's a paid political announcement. The number is S211, surprise, but we have this incredible 211 system across the country that people call into for help and assistance. Those are the numbers from that.

What I want to point out to you is one, you should think about mental health and health in the same line. And so

you will see, given those numbers, the combination is the second largest number of calls but what we know from running a local 211 is it isn't just those calls, what you see in terms of housing insecurity, income support and food insecurity usually comes down to not always but frequently the fact that people don't have health care coverage. When we counsel them, what we find is that is why they can't afford the others.

A local twist is we use our 211 number locally to do outreach for SCHIP. In two months last year when we were doing outreach for SCHIP what we found was we increased calls by 133 calls and that was great and significant for our region but general health care calls increased by 36-percent just from the advertising that there was someone who was willing to talk about health care coverage.

I will skip my next slide and just tell you no matter what background we come from up here we are coming to you asking for similar solutions. I have three not too simple recommendations but very important ones. Reauthorize SCHIP. It is effective, it is cost effective, it is a great economic stimulator in and of itself. It needs to be improved. It has to have enrollment streamlined. We have to increase retention and we do have to outreach to low income families because they are hard to reach.

FMAP is the best economic stimulator Ohio has seen. In 2003, it helped bring us back from the edge and no other

strategy including tax cuts has that same effect. The third thing we would like to see is comprehensive health care reform and a great way to start is to look at the Medicaid model for both adults and children. Thank you.

ED HOWARD, J.D.: Okay, quite an array of presentations to consider as we go forward. Now it is your turn to get into this conversation. If you can fight your way to the microphones, they are right up here, let me just take care of a couple of logistical things if I can before we start. There is a green question card in your packets. If you would like to fill it out and hold it up, someone will come by and bring it forward so that we can ask it from here.

There are a couple of things in your packets I want to call attention to. One of them a flyer points out that as of 10:00 a.m. on Monday, you will be able to watch a webcast of the briefing on KaiserNetwork.org. There are also electronic versions of the materials in your packets including some of the ones that were late arrivals and were not able to get into the packets, and finally there is the ubiquitous blue evaluation form which we would urge you to fill out so that we can make these briefings as valuable as they possibly can be from your point of view.

So, we are pleased to entertain your questions. We have a few that have been submitted in advance while we are

waiting for you to scoot up your courage and get to the microphone. Diane do you want to start us off?

DIANE ROWLAND, Sc.D.: Sure, the first question we have is according to press accounts, in President Elect Obama's economic stimulus plan, nearly $80 billion is proposed to go to state Medicaid programs, facing increased demand due to the rising unemployment, given the discussion today do the members of the panel think this is sufficient funding to support Medicaid programs already facing tight funding or what is your alternative?

STAN ROSENSTEIN: The question was is it sufficient?

DIANE ROWLAND, Sc.D.: Yes.

STAN ROSENSTEIN: No. [Laughter] Just to give you a sense of the numbers and if California is facing a billion dollars alone in one year in cost and a $15 billion drop in revenue, it is a big gap to fill, if you look at the Medicaid portion, when Medicaid is staying the largest general fund part of the program, of the state, I'm sorry.

DAVID PARRELLA: Another thing I would add is that relief for Medicaid should not just be a 12 month phenomenon because the needs of Medicaid are going to lag behind in the economic recovery so whatever number congress and the president in their infinite wisdom come up with, it has to be extended over a period which is longer than 12 months and we would think 24 months would be reasonable.

MARGARET HULBERT: If I could also, what we are seeing in Ohio with the economic downturn and Ohio is particularly hard to hit, quite frankly, it's no longer the typical state in the country, we anticipate by the end of March we will have a 9-percent unemployment rate and it may even be higher because we lose 10,000 jobs in the next quarter that we know of right now.

Because Medicaid is counter cyclical, not only do we need help with an enriched rate to just deal with what is happening in the states but the increased numbers will drive up that need significantly as people come off of work and need public assistance. Over 30-percent of the people who are currently on public assistance in Ohio have never been on public assistance before and so that is going to drive the need much higher.

DIANE ROWLAND, Sc.D.: The second question relates to a complementary way of getting health insurance coverage, which is the COBRA program where you can extend your employer based coverage but that is by paying 100-percent of the premiums and this questioner notes since COBRA premiums are so high, what are the alternatives or the implications for using Medicaid or other programs as a way to help subsidize coverage?

Is there a link between COBRA and Medicaid that should be thought about? Is there a way in which COBRA is really

putting additional pressure on Medicaid because it is so expensive?

DAVID PARRELLA: We have had some experiments with COBRA buy-in programs. Like a lot of states when we first saw the impact of the HIV epidemic in the 80s, we actually started programs to buy-in to COBRA continuation benefits to subsidize people as a way of keeping them off of Medicaid, that we thought it would be cost effective. And it has worked.

There is a small number of people every year for whom that works but first of all you have to have had a job that had insurance to take advantage of COBRA. That is problem number one, and some of these folks don't. They are losing employment where there was no benefit. And second of all depending on where you worked, what you pay in COBRA is 102-percent of your last group premium, and that can be quite expensive and whether that is really cost effective as opposed to another way of providing coverage to folks, it depends.

I think states have done a lot of work, probably a lot more than we have in Connecticut, looking at these ideas around premium assistance where you use Medicaid to help people who are decliners choose to stay in employer packages. It can be effective. It is very complicated to administer under current federal rules.

STAN ROSENSTEIN: California also buys in COBRA when it is cost effective, often it's not because often the COBRA

expenditures are much more costly than just Medicaid alone. The limitation Medicaid has on COBRA that people really need to understand is that not everybody who loses their job is eligible for Medicaid.

You have got to be categorically linked and in California at least that means you have got to be a parent with a deprived child, which means if you are unemployed you would be but not everybody who is even a parent qualifies for Medicaid and people who are childless don't qualify so there is a big limitation on Medicaid.

DIANE ROWLAND, Sc.D.: We have a question that says I am new to Medicaid but can you tell me what are optional and mandatory populations and do you expect more states to cut optional populations? And the key question, who will provide these people services without Medicaid?

ROBIN RUDOWITZ: Well, federal law provides broad guidelines or laws for what states need to cover in terms of mandatory populations and benefits, so all children need to be covered at least up to 100-percent of the poverty level. All states across the country have really expanded beyond the minimum levels for coverage, particularly for children, and most states in the country, well all states in the country also cover what are really optional benefits, like prescription drugs is really an optional benefit. So the terms don't necessarily categorize that these things are not important and

it is very difficult for states to cut them, even if they are not mandatory.

DAVID PARRELLA: Could I just add one thing there, I think it has been touched on before but this is really Medicaid 101, so I apologize to everyone that was already aware of this but a lot of people think that there is an income standard for Medicaid that if you are poor you qualify and that is simply not true.

You could be a child at 100-percent of poverty and be eligible. You could be the mother of that child and be eligible but if you are just a single person, a non disabled single person, kid out of high school, kid out of college, kid coming back from Iraq, wandering around looking for work, not disabled, doesn't have dependent children, just a single person unemployed, there is no way you are going to be eligible for the Medicaid program.

There is no categorically needy standard that is going to apply to you. Now in our state like in a lot of states we have state funded programs for those folks. We have a general assistance program that provides kind of a Medicaid Light version for those people for a period of time but the idea that just because you are poor, you are on Medicaid, is not true, definitely not.

DIANE ROWLAND, Sc.D.: David let me also ask you though, you said you have state funded programs for those

people, aren't those programs also in great jeopardy during economic time senses?

DAVID PARRELLA: The state funded programs are probably more in jeopardy because we don't get federal match. Now, through various devices that Medicaid directors don't like to talk about, we go back in rooms and we make this stuff up, we actually claim part of those costs under our hospital dish program because the care that we are providing is state funded, uncompensated care.

When they go to a hospital inpatient, outpatient department, we manage to get federal revenue on that. That is getting harder and harder to do in the current regulatory environment but yes, a state funded program is probably more vulnerable than Medicaid.

MARGARET HULBERT: And not all states have state funded programs.

STAN ROSENSTEIN: And due to respect to the great state of Connecticut, not every state has state funded programs. In California if you become uninsured, not on Medicaid, you can go to the county programs which vary by county, of federally qualified health centers, or you are responsible to pay on your own.

ED HOWARD, J.D.: Let me just interject, one of the things that is kind of confusing is that there are both voluntary, mandatory and non mandatory services, and voluntary

and mandatory populations, and I wonder if there is any further distinction that you want to draw about what is happening to the population lots?

DAVID PARRELLA: I mean, during the last round we eliminated coverage for optional services so for example we got rid of chiropractic coverage. We eliminated coverage of podiatry which was actually I think was a big mistake, given our long term care population and their podiatrics, but we no longer cover podiatry for adults. It is an optional service, but the list of optional services is fairly misleading. When the federal government says you have got a lot of flexibility because of these services are optional, pharmacy is an optional service.

I don't think there is any Medicaid program or anybody would run a program other than Medicare. Medicare ran a program without pharmacy for awhile but they were onto something that we didn't know about but pretty much everybody has to have a pharmacy benefit, even though technically it is an optional service. And there are some other examples. I am sure Stan can think of over there.

STAN ROSENSTEIN: The optional populations, actually the Medicaid requirement for coverage of parents is very low. It is the 1996 Welfare Standard and for the disabled, all you have to cover is people who are on SSI, them and seniors, and as I mentioned California has under consideration major roll-

backs in the optional populations because of its budget program. California has also got optional benefits.

When you look at severe budget cuts, optional benefits don't generate very much money. What really generates money is taking people off the program is what generates the savings so if the financial crisis is allowed to continue, states who have optional populations are going to be forced to do roll-back and put thousands if not millions of people into the ranks of the uninsured.

DIANE ROWLAND, Sc.D.: Recognizing that many of the uninsured as well as Medicaid patients get care from community health centers; this questioner asks whether there should be money included in the stimulus for community health centers to help provide that as a source of care in addition to whatever Medicaid money is in the stimulus?

DAVID PARRELLA: Well community health centers play an important role in serving the uninsured population and Medicaid plays an important role in funding community health centers. Community health centers have a unique relationship with Medicaid in that they receive a prospective rate which many of our physicians would be envious of.

So, yes I would think that the idea of expanding funding for community health centers plays a role but community health centers can only do so much. I mean they are there to deliver primary care and I am not knocking that. That is

extremely important but if you get primary care and someone discovers that you need a referral to a specialist, what happens? Everything can't be done within the walls of the FQHC.

STAN ROSENSTEIN: I would add in addition to community health centers which are vital to Medicaid, the same issue applies to this proportion of share hospitals and both groups are seeing growing numbers of uncompensated care because of the uninsured. They get doubly hit if Medicaid is not supported because Medicaid is the financial driver for both the community health centers and the disproportionate hospitals, at least in California.

ED HOWARD, J.D.: Yes you have a question at the microphone?

DEBORAH LIPSON: Thank you. My name is Deborah Lipson. I am with Mathematical Policy Research. We often used to say in previous economic crises that sometimes there lay an opportunity to do the things that you might not have been able to do without those crises so my question is asked in the spirit of that. Many of the things David that you suggested would shift costs to the federal government.

Some of the things that you have suggested, Stan, that are being considered in California, again go to the optional categories of eligibles and other optional benefits. But I am wondering whether there may be some things that are currently

required by federal law that if there were changes in federal law stimulated by the crisis would give you, at the state level, some flexibility to reduce costs that you may not have had otherwise.

And particularly here I am thinking about the long term care sector for the elderly and people with disabilities where most of the expenditures lie. Is there anything that you wish could be done given the extreme circumstances that we now find ourselves?

DAVID PARRELLA: Well I think we both have a lengthy list and you are correct in your observation that a lot of times it takes this kind of a crisis to really create tackling some problems that people have shied away from. I mean it was mentioned earlier that during the last recession a lot of states led by my colleague Stan did a lot of pretty aggressive things to control prescription drug costs.

I think if things had just muddled along we might not have had preferred drug lists and prior authorizations and mandatory generic substitutions and things that have really picked off a lot of low lying fruit to control pharmacy costs, but you are right. I mean there are other things that could change in the law that could deliver the same Medicaid benefit at less cost with greater quality and client satisfaction.

One of the things I touched on briefly, it is very complicated for Medicaid to look at any kind of premium subsidy

program to provide coverage to people in the private sector, to buy-in. It is a concept that states struggle with but the rules around how you have to go about doing it with the Benchmark plan and actuarial equivalence, it is a full time employment act for actuaries, basically, but it is not really benefitting people very much.

So, some more straight forward design of that could be another solution. In long term care, you know, everybody talks about rebalancing or money follows the person to state, everybody is trying to change their care delivery system away from institutional care to the community but there are still basic premises about Medicaid eligibility that are greatly slanted towards favoring institutional care in terms of determinations of eligibility for clients.

I mean, you have got to be able— we find this rolling out money follows the person where we have some people that have been in a nursing home for more than six months. We interview them. We set up a care plan to transition them into the community. The good news is you can transition them into the community. The bad news is you won't be eligible for Medicaid anymore. As long as that kind of dichotomy sort of stays there you are not really getting at the kind of paradigm shift that I think we are all about in terms of rebalancing.

DIANE ROWLAND, Sc.D.: This question relates to yesterday. Our President Elect Obama talked extensively about

health IT as one of the investments in an economic stimulus and infrastructure rebuilding project. The question here is health IT is seen by many as a way to squeeze out costs and improve quality. What has Medicaid's experience been? Do EMR's work well? Is ERX working well? What can we expect from health IT for Medicaid?

STAN ROSENSTEIN: The only thing I would add, I think also there is a tremendous opportunity and the other thing I would love to see of this process is really a new and improved relationship between the federal government and the states. I think there is a lot that could be done in that area. And the things that could be done out of the opportunity are not going to solve the crisis. I want to be clear on that. The crisis should forge opportunity but the crisis is so major that it won't do it alone.

DAVID PARRELLA: On the health IT front, we have a big project going now with the e-prescribing to try to get better productivity and feedback between physicians and our Medicaid claims processing system as far as prescriptions are concerned. It is kind of one piece of trying to put a statewide EHR out there. It is just one piece but we are starting with that, and that has a lot of potential.

I think a lot of this stuff is very exciting but I would caution people against thinking that you are going to sort of bit and bite your way out of the problem. I don't know

that the elves really have the solution to what is going on with health care costs. I mean all these are tools that can be beneficial but I don't totally put my faith in technology.

ED HOWARD, J.D.: Can I just crib from another question that came in on this same subject, is it possible that by using electronic records to streamline say intake processes you might actually increase costs by making them more efficient?

MARGARET HULBERT: Putting more— increasing enrollment?

ED HOWARD, J.D.: Yes enrolling more people more quickly.

DAVID PARRELLA: Well I mean it is true that to the extent that you move towards an online application system in this age where people can go online and complete their applications, you are going to get at some of the backlog that resides in county and state offices relative to applications and perhaps speed up the time limits, the time that it takes to get someone onto the program.

I think that we are so far away from that in our state right now though, I mean we are struggling with backlogs for case determinations that probably don't satisfy the current federal requirements so I think we would be far away from the point where we would be really sort of piling on the roles, even if we update it.

ED HOWARD, J.D.: Yes, go right ahead.

STEWART GORDON: Stewart Gordon, Safety Net Hospital's Pharmaceutical Access, David mentioned that the CHC's have been picking up a lot of the burden of the uninsured. Stan mentioned that the disproportionate share of hospitals are sharing in that burden. My organizations had some inpatient legislation in for the last few years that would extend the 340B discount drug program to the inpatient population. I would like to get your thoughts on how important an element that should be in dealing with the health care crisis?

ED HOWARD, J.D.: And someone might want to explain what the 340B reference is.

STAN ROSENSTEIN: I think the 340B program is a terrific program and I would support the concept of expanding it. I think the other thing that could be looked at is should Medicaid managed care plans be able to get the Medicaid drug rebates and be exempt from Medicaid best price? There is a world of opportunity in Medicaid to do more savings through drug rebating. The Medicare plans are able to do drug rebates now that are exempt from Medicaid best prices. It is time for the Medicaid plans to be able to do that also.

DAVID PARRELLA: 340B is a federal program where public— centers funded by the public health service including FQHC's can get access to what is basically the government's best price in buying drugs. It's the price that the Department of Defense basically pays. You can't get any lower than that.

And, there are ways today for disproportionate share hospitals to get access to 340B pricing but it is very difficult and they have to pass some pretty impossible statistical tests. We had our largest disproportionate hospitals, Yale New Haven tried to go through that and despite the fact they are our largest provider of care to Medicaid and the uninsured, they weren't able to qualify for a 340B because of something in the rules that just tripped them up.

I agree with Stan. I mean it makes sense. I mean, I have to be a little cautious here. I come from the state that has the second highest number of pharmaceutical manufacturer headquarters, next to our friends down the road in New Jersey, so I can't speak ill of the pharmaceutical industry but clearly anything we can do to control the outlay of costs of prescription drugs, which has been happening for the last five or six years.

States have gotten a lot smarter about how they have dealt with it, but there are still some new products emerging now that we are only really starting to feel the impact of. And you can talk about the good health benefits, but the biologics, the $1,000 synergist of injection that takes the place of the inhaler for asthma, getting to be more widely prescribed, things like that are continuing to be cost drivers in the program and as the whole genome revolution goes forward you are going to see more and more of that.

DIANE ROWLAND, Sc.D.: This question relates to the history of assisting states during an economic downturn. In the last recession when states got an increase in their FMAP or their federal share of Medicaid spending, one of the conditions was that they not reduce their eligibility levels beyond what those in effect when the legislation was passed.

This question asks what would be the impact of an eligibility maintenance of effort requirement this time? Would state Medicaid programs be able to continue their programs and is this a tenable approach to be matched with an increase in the federal matching percentage?

DAVID PARRELLA: I would say the answer is yes. It is tenable. I think that last time we got FMAP relief, at least from my experience it played a vital role in sustaining eligibility in Medicaid programs in my state and lots of states. I think that even with an FMAP increase for some temporary period of time you are still likely to see increases in cost sharing, even with the FMAP increase people might still be eligible at the same levels but there might be where states don't have copayments, you could see copayments, where there are no premiums, you could see premiums. I think that kind of thing is still possible even with an FMAP relief, only because the hole is as great as it is.

STAN ROSENSTEIN: I would also point out that the last time the maintenance of effort level was very narrow. It just

pertained to changing the eligibility level. You covered 100-percent or 85-percent. It didn't pertain to could you increase cost sharing or other things.

I think the fiscal reality of the states is that maintenance of efforts are fine and workable but the funds have to be able to enable the state to meet the maintenance effort. You can't give a state a dime and say keep your program the way it is, to give you an example, the maintenance of effort has got to tie to how much money is involved in the transaction.

ED HOWARD, J.D.: Yes, Bob?

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health. The panel has focused on the state responsibilities for the Medicaid program and it is a significant portion of the budget, like up to 20-percent, but we haven't talked at all about state opportunities and responsibilities for public health in general, which can address the kinds of causes of the health problems, as the speaker from the United Way mentioned.

Instead of focusing on trying to ration the limited Medicaid dollar or shift those costs to the federal government, what activities can states undertake to address more efficiently and effectively the causes of health problems, not just for the Medicaid population, but for the total population?

That is kind of the challenge that Deborah mentioned in saying what is the crisis and what are the creative solutions

for it? Instead of just looking for creative solutions within the Medicaid program, what are creative public health solutions that states ought to be taking now?

DAVID PARRELLA: There are a lot of them and I think a lot of states have bridged that gap pretty effectively with public health measures. We are a universal immunization state. In Connecticut we have a very high rate of immunization compliance, both in our Medicaid program. We got very interested in blood lead. We have a lot of kids in inner cities that have high blood lead levels.

We have a program now going where we actually go in and do lead mitigation in low cost housing because again it is the argument we are going to treat these kids if they have toxicity from the lead. It makes sense to start going after— we have, I think, the second oldest housing stock in the country, particularly in the inner cities near highways so there is a lot of exposure of Medicaid children, very young children, to lead.

So bridging out and to start looking at some of those non traditional Medicaid activities that can sort of head off some of the consequences that you are going to be treating. I could give you other examples but part of it is that there has to be flexibility from the federal government side to allow funds used in Medicaid to sort of make some of these kinds of modifications.

And a lot of times the response that comes back is that is not something that Medicaid can do. So you need to have support for preventive activities, environmental activities, weight control, smoking cessation, the whole array recognized as medical activities.

Medicaid has traditionally had sort of a narrow definition of what was medical as opposed to I think where you are going which is to say let's think about how we could address some of these issues like the development of Type II diabetes in young children these days, you know, that's something we didn't see 20 years ago.

It is going to be with us as a cost for a long time. We have a parent focus group that talks about issues with their kids and I was talking to one of the moms about obesity and don't you think your kids should get more physical activity, trying to say that kind of stuff, and her response was well in my neighborhood I don't let my kids out of the house because it is dangerous. There are too many gun shots. That is a sad reality but that is some of the kinds of things that you have to get at somehow.

MARGARET HULBERT: I have a very limited example of it but I think in truth public health works best when it is in combination with Medicaid. We do a great deal of funding of home visitation for prenatal and very young children in both of

our states and because of that we do lead screening, we do vision, we do hearing, we even do social and emotional.

Some of that is private dollars from us, but we have a very strong program in the state of Kentucky because whatever is Medicaid eligible is covered by Medicaid. In Ohio it is not Medicaid eligible, so our program has essentially been disappearing because there aren't enough public health funds in either state to sustain it but because Kentucky could make what it could Medicaid eligible. It has been able to sustain it with that and private dollars.

STAN ROSENSTEIN: Tremendous opportunities in preventing and managing chronic diseases, tobacco, obesity, diabetes, what we found also, I always feel like I'm a bringer of bad news, is these programs initially cost money, they save money in the long term, they cost money in the short term, and unfortunately when you get to tight budgets of the policy makers and they are not mandated and do not want to fund those because they are cutting everything else in the world so I would add there needs to be funding for prevention activities and a lot of it has to be done before people qualify for Medicaid, really broad based, which is what public health has been doing for years.

DAVID PARRELLA: One other issue that we haven't really talked on, touched on, I was glad to hear that prevention

component come in because it is part of a larger, clearly you have got to do that.

If you do all of this and you don't address that, you haven't done anything really. But work force is a big issue. I haven't really mentioned it. None of us have mentioned it here. Up the road from where I live is the common wealth of Massachusetts who has probably done about as much as anybody has done about expanding coverage but they are starting to see in the areas away from Boston there is a real shortage of primary care providers for these people once they do become eligible for a program.

We already have that in a more limited context in Medicaid in our state, probably in all the states because providers are reluctant to participate in Medicaid for reimbursement and other reasons, but even when you craft an expansion program to bring in additional populations, if you don't somehow address that work force issue it is questionable about how much effective health care delivery you are really going to be providing and I think primary care is really the key.

BARBARA CORNBLOW: My name is Barbara Cornblow [misspelled?]. I am with Special Olympics and one of the things that we would like to see, we are very concerned about increasing the level of activity. We also agree that a lot of people are concerned that their neighborhoods are not safe.

We would like to see as part of the economic stimulus package fixing schools and fixing P.E. facilities so that they are accessible and usable and encourage, you know allow the community groups to use those so older people can use them for exercise, not older people can use them for exercise, kids can use them, and people with disabilities. Has there any thought gone into— have you all thought about anything like that?

DAVID PARRELLA: Well, I agree with you. I think those are all good things and President Obama should listen to you, [laughter] wherever you are. But my response is that we have tried to work with schools around health programs, around outreach for Medicaid, particularly around special education issues, Medicaid coverage of services covered under IEP's.

And one real problem, and I am sure Stan has experienced this too, is that the attitude over the last eight years has been very rigid about Medicaid's involvement with education, that somehow when Medicaid— I mean we see Medicaid as being kind of enterprise wide relative to education/prevention.

It touches all these programs but the outgoing administration has viewed Medicaid involvement in education with a great deal of suspicion, that it somehow— Medicaid is being asked to pay education's bills and that some of the regs we're struggling with right now actually make that even harder. So, I agree with you but I think we have to have kind of a

culture change in the CMS folks if you are really going to be able to make that happen.

MARGARET HULBERT: Not to that specific issue but to the specific issue of culture change and CMS, one of the opportunities and for those of you who deal with Medicaid a lot this is old news but for those who don't and there are some of you here, enrollment issues are huge, particularly for me in the SCHIP population.

We spend so much money re-enrolling children as they churn in and out of the system because parents are required to come in and I've seen a number of times to re-enroll their children and these are low income, struggling parents without transportation and who are really trying to get to go to work in jobs that don't permit them to take time off.

But almost anything that we could do to make it easier to enroll the hardest to enroll, either CMS doesn't by policy allow or it discourages states from allowing when states control. And so viewing it as a cost saving measure to keep kids off, it doesn't make sense because for the rest of the population who is trying to enroll people for the health care system that is trying to deliver services to them, it becomes a double burden to re-enroll these kids and frankly we lose lots of them.

ED HOWARD, J.D.: Somebody at the microphone.

DOUG TRAPP: Hi, Doug Trapp, American Medical News, Robin mentioned past criticism of the old stimulus, the old FF increases coming too late, is the current one in danger of coming too late or not?

ED HOWARD, J.D.: [Laughter] you beat Diane reading your written question by about ten seconds. What do you think folks, about the timing?

MARGARET HULBERT: Yes.

DAVID PARRELLA: No time like the present. [Laughter] States need it desperately now.

MARGARET HULBERT: And many states are currently introducing their next budgets. February 2nd we will release ours. It is going to be a very different budget that will be released than it would have been had the next stimulus package passed down. States have to balance their budgets. We will weaken the cuts before the package has been put in place.

DIANE ROWLAND, Sc.D.: There is a question out here that maybe all of you would like to answer in light of that, what are the arguments against the FMAP expansion? Does anyone? [Laughter] None, huh? [Laughter] Well the arguments -

STAN ROSENSTEIN: The only one I've heard is you ought to not do it because it forces states to make hard decisions or reform their programs. That is the one I've heard and my two

responses to that is first of all states have been under pressure to reform their programs for a number of years.

That is why I started off my discussion with California being the lowest per capita expender that we have been cutting, cutting, cutting, and then the second response is that you can't creatively change your program to get out of this economic problem. The reforms that people talk about, more co-pays don't save as much money as states have to save now.

DAVID PARRELLA: I've heard that the argument against it that it is just not shovel ready jobs. That seems to be a slogan that has gotten very popular lately, that somehow it is not like immediate job incentivising and that there are other ways to spend money other than FMAP that would create employment.

That may be true but I think that clearly the FMAP maintains the integrity of a pretty important chunk to the health care system and the health care system is a pretty large part of the economy in a lot of our states so I don't know that even though it is not pouring bricks and mortar it isn't in some way a stimulus.

ROBIN RUDOWITZ: Non arguments against the FMAP but one of the other benefits of the FMAP from the last time was that it was a quick way to get relief out to the states as opposed to the block grants that were provided that took some time to get out. The FMAP was already a system that was set up so it

was efficient and expedient and getting money out that the states desperately need to get to David's point as well.

MARGARET HULBERT: One of the advantages of FMAP, I saw the block grant or part of the stimulus and some of it was brilliant and some of it was ridiculous. And Medicaid is a solid program and FMAP strengthens a solid program.

ED HOWARD, J.D.: There is the materials a piece that quotes Bob Healms from AEI with what might be considered a criticism of the FMAP, although not of the FMAP increase, just of the FMAP, that is that the formula itself is either outdated or weighted too much toward pardon me rich states like Connecticut and California relatively speaking.

DAVID PARRELLA: Oh, don't listen to those people.

STAN ROSENSTEIN: Weighted against states like California. [Laughter]

ED HOWARD, J.D.: I guess the real question that raises is this the time to look at the fairness of the FMAP formula?

DAVID PARRELLA: Well, I think there is always criticisms that you can level about the FMAP formula including the counter cyclical nature of it all the way down to how you calculate what each share each state gets, and I am not going to sit here and tell you that the FMAP calculator right now is perfect.

I would caution against trying to talk about an FMAP expansion right now in the midst of revisiting the whole

formula because the few times that I have been around when that has been done, that becomes a real food fight amongst the states where the southern states say all you rich Yankees up north, you know, you are getting more than you really should get then the rich Yankees up north say yeah but we don't get much back from the dollars we pay in taxes.

It all goes down to you. [Laughter] Then, you're trying to get a consensus is pretty tough, it's difficult. So, I think as a tactic, as a strategy, that could really put off being able to get agreement on anything if you open that up right now.

DIANE ROWLAND, Sc.D.: David there was one point you made earlier about the lag in the FMAP calculation, too. Maybe for this group it would be useful to explain the time delay and why increasing it now can help get over the fact that you are basing your FMAP on an earlier year.

DAVID PARRELLA: Well, some states, not us because we are rich Yankees from up north, some states have a variable FMAP which is adjusted based on their economic performance two years prior so there are states now in the midst of an economic downturn, Ohio, places like that, who are actually if nothing is done are going to see their FMAP go down this year based on economic activity that happened two years ago.

So just when you need it most, even if you didn't give people a stimulus, even if you just froze them they would be

better off but they are scheduled to actually be reduced on their match rate, that is really pouring salt in the wound.

ED HOWARD, J.D.: As I recall, the lifetime around one of the provisions in the FMAP increase was giving states some flexibility to use either prior or coming FMAP rates if that were to their advantage. I haven't heard much discussion about that in the context of this stimulus package but it's worth remembering.

STAN ROSENSTEIN: The other thing that happened last time which I thought was very effective is the FMAP relief was front loaded so if you looked at they had three tiers, the first time the states got the money was the highest rate so the money came in very quick and very immediately and then it dropped down and it gave a very, very quick boost.

MARGARET HULBERT: Just to follow up on the FMAP numbers of reductions, I think the previous views that the senate and the house considered in September and November did have a harmless provision that would have said if a state was scheduled for a reduction they would not have that reduction so that you would get that recognition that your unemployment rates were going up which depleted your revenues and added to your shortfalls.

One of the things that some republican senators have said is that there should be a loan and if this aid to states was a loan it would force states to be more frugal and more

judicious in their spending of that money. It is hard to conceive of an increase in FMAP as a loan. I know you may not be state sort of constitutional or legislative scholars in that but I know that there was a sheet handed out and I just wanted to ask what would be the problems if an FMAP increase was likely to be a loan?

DAVID PARRELLA: It is hard to contemplate a loan in the form of FMAP because we do budgeting, balance budget projections for two years so you would have to figure into that your repayment schedule for your surplus FMAP on some sort of long term basis. That makes my hair hurt to think about that. [Laughter] I don't know. Stan doesn't have any hair. [Laughter]

STAN ROSENSTEIN: Yeah I think it would create enormous conflicts in states, like California for example has a constitutional prohibition about borrowing money without a voter approval, so I'm not sure how that would be constructed but depending on how it was constructed in California might have to go to the ballet in order to even take the loan.

I expect California is not the only state that has that restriction and I think it is not accurate, at least in the states I am aware of, to say that the states are spending frugally, spending wildly and you know, the states have been under enormous pressure to reduce their Medicaid budgets.

And I am not saying every state has, but most states have done the hard stuff. I think the Kaiser survey shows and states are going to look at the short term, how do I get through this financial crisis and how do you survive? You know, California is a state that actually has borrowed and you end up spending an enormous amount of your general fund on debt service and states just can't continue to borrow and borrow and borrow. That would just be another borrowing.

MARGARET HULBERT: If you also look at the position states are in right now, first of all very few of them are flush. Most of them have repeated years of cuts and many of them are going to have to borrow to pay unemployment compensation and so at what point do you stop doing that?

DAVID PARRELLA: I guess the other thing that I would add to that is that if you don't think that states are frugal in the administration on their Medicaid agencies, call your local medical society and ask them what they think about Medicaid reimbursement [laughter], whether they think that they are being overly compensated for the services or your local hospital association, ask them.

I think in most cases we were very proud of the fact that with our last rate increase we were able to raise physicians' rates from 47-percent to 57-percent of Medicare allowable amounts. For EPSDT kid services were at 85-percent and for maternity OB because that is such a huge area for us

where we pay like 120-percent of Medicare allowables, but generally speaking we are a little more than half of what Medicare allowables would be for a comparable surgery office visit and we are probably one of the higher states at that.

ED HOWARD, J.D.: Well, we have had some sobering thoughts and some very insightful comments for you to chew on as this issue makes its way through congress and to the other end of Pennsylvania Avenue.

And let me just take this opportunity to remind you that it would be very helpful if you would fill out the evaluation form as you leave. And take this opportunity to thank our friends at the Kaiser Commission for their real substantial role in helping us shape this briefing and recruit knowledgeable people from out of town so that we aren't always giving you the same experts as we always do.

Thank you for sticking with it, through this sometimes fairly detailed and complicated issue, and ask you to join me in thanking the panelists for bringing us a message we needed to hear. [Applause]

DIANE ROWLAND, Sc.D.: And we will try over the course of 2009 to bring you a few more uplifting briefings. It is kind of hard to start this way but this is the reality. Thank you.

[END RECORDING]