Medicaid: The Essentials

Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured

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ED HOWARD, J.D.: We do as you might imagine have a few seats up front so if you are looking for a place to light, there you are. My name is Ed Howard. I am with the Alliance for Health Reform, and on behalf of Senator Rockefeller and Senator Collins and our board of directors, we want to welcome you to this program on the basics of Medicaid. You know this, but I'll bet there are a lot of people who are watching this who do not, and that is in terms of enrollment anyway, Medicaid is the biggest health insurance program in America.

Over the course of the year, it covers more people than Medicare, 60 million or more, one in every five people in this country, and it is costly, counting both the federal and state government shares, its price tag is somewhere between $340 or $380 billion this year and there are three other things that you ought to know about Medicaid, actually there are probably a few more than three but there are three that I am going to take the time to share with you at this moment.

First, it is incredibly important to the millions of low income Americans that it serves. Second, it is incredibly complicated and it is differently complicated in every state and other jurisdictions in which it functions. You will hear more about that later. And third, it is a moving target, both nationally and in many states. The stimulus package that congress may clear today has several Medicaid provisions,

important ones, and on the other hand a lot of states are grappling with budget woes and looking closely at their Medicaid program and how they are going to have to deal with those two items simultaneously. So we are really pleased to bring you this primmer on the Medicaid program.

Our partner and cosponsor in this briefing, the Kaiser Commission on Medicaid and the Uninsured, is a lot of you know a project of the Kaiser Family Foundation. Diane Rowland, who you will hear from presently, is the executive director of the commission and coincidentally one of the country's leading Medicaid experts.

Now, we want to not only welcome those of you who are here in the room, but also those of you on congressional staffs in state and district offices who are watching live on a webcast being brought to you by Kaisernetwork.org. We want you to understand the basics of this important program. You have case work to do sometimes. You have constituent questions and we want to help you deal with those situations as well as we can. Thank you very much for tuning in and we will look forward to hearing from you later in the program.

In your packets, those of you who are here, there is an awful lot of background information including speaker bios that are more extensive than you will hear from me. You will also find all of the Power Point presentations in hard copy and of course you will see them on the screen. Those around the

country can find the presentations on our website which is allhealth.org.

In a few days, you are going to be able to view a transcript of today's discussion and copies of the materials that those of you in the room have in hard copy at both kaisernetwork.org and allhealth.org, download a pod cast, listen to it on the subway, you will be edified.

And, at the appropriate time, those of you in the room are going to get a chance to ask questions. There are green cards in your packets. You can come to the microphones of which there are three in the room and there is a procedure that we have set up for state and district office folks to e-mail the questions at the appropriate time to an address listed on our website.

So, before we go any further, let's get going with the program. We have got a terrific group of experts today. We have got presentations that you can follow along with in your packets and people who can answer any question you have about Medicaid, whether it is very simple or very complicated.

So, I want to start obviously with the gentle lady to my right, Diane Rowland, our first presenter, and she will be comoderating as well. She is as I said one of the country's foremost authorities on Medicaid and as executive director of the Kaiser Commission and the executive vice president of the foundation; she deals with it almost every day.

She has been a professional staff member on the hill dealing with Medicaid, she has been in key positions in the executive branch, and her task today is to give you a broad overview of the provisions of this important program and we are very lucky to have you to set the stage for this discussion. Diane?

DIANE ROWLAND, Sc.D: Thank you, Ed. I think what Ed has just told you is that Medicaid has been around for a long time and so have I. [Laughter] So, today we will try and take you back a little bit to the roots of Medicaid and what it has developed to be as well as try and explain some of the basics. This is not about policy choices for how Medicaid should be reformed or changed.

This is about how a very complicated program takes care of very complex populations and in doing that covers as Ed said a substantial share of the American population at a substantial cost to both the federal government and states and ultimately to all of us.

What I wanted to start with, though, is to remind you that this is in fact an old program. It was enacted in 1965 as a companion to the Medicare legislation. It was intended to improve the states' ability to provide coverage to their welfare populations. It entitled eligible individuals to a defined set of benefits but it did give states a great deal of

leverage in that they could set benefits and provider payments and also the coverage under their own rules.

It is an foremost has remained a means tested program, so that it started with the focus on welfare, but it has always had income eligibility as one of its criteria, yet it also started with the welfare hang up, which is that welfare under the Elizabethan poor laws was really for aged, blind and disabled individuals as well as single parents with children. They were the needy poor.

Those who were without children and without families to support and without disabilities were not eligible for coverage under welfare, not eligible for coverage under Medicaid, no matter how poor. So when we talk about Medicaid, we always talk about its eligibility as income related and categorically related and over time there has been some broadening of the categories and some broadening of the income, but the roots are there in the original thoughts that Medicaid would be the health insurance program for the welfare population.

Today, Medicaid really goes far, far beyond that, and as a program by the way I should note is under the jurisdiction of, in the senate the senate finance committee, and in the house the energy and commerce committee. Sso those are the authorizing committees for this program. Today Medicaid’s coverage is broad and its roles are multiple and I think that is the most important thing to remember about the program.

We often hear it talked about mostly in connection with its role for low income children in providing health insurance coverage to over almost 30 million of the nation's children but it also is a key cornerstone of our long term care system and the only place in which individuals can really turn for help with substantial long term care bills.

It also provides wrap around services to Medicare beneficiaries, filling in and paying their premiums, some of their cost sharing, and providing additional benefits that Medicare doesn't cover. Many like to say it is the Medicaid program that makes Medicare work for low income beneficiaries.

In doing that, it is a major component of our health insurance system, providing 16-percent of overall national health care spending so it is a big payer and a big player in the health system but especially a big payer and player for long term care where it covers some 42-percent of all long term care, institutional and home and community based spending in the U.S.

As our other speakers I am sure will address, it is a very big piece of state financing for care of their low income population under a complicated formula known as the FMAP. It picks up between 50 and 76-percent of the spending that states encounter on Medicaid. States have to provide matching funds and Barbara I know will get into more of that.

It is the largest source of funding to the states, 44-percent of all federal funds to the state flow through Medicaid, and so I know many of you have probably been hearing about Medicaid in the context of the stimulus, that is one of the big pieces of getting additional federal support out during this economic down turn.

I think it is also important to remember that Medicaid takes care of a wide range of individuals and the selected populations for which it provides coverage are among the nation's poorest and sickest. It covers around 40-percent of the poor and 23-percent of the near poor. It leaves out as I said childless adults and many who don't meet the income eligibility test in the states that are often far below the poverty level, especially for adults.

It has a much more substantial role for children and covers more children than it does their low income parents. It is a major source of coverage for pregnant women and covers some 41-percent of all births in the U.S. It covers one in five Medicare beneficiaries for those wrap around services and it covers 20-percent of people with severe disabilities.

As the nation has struggled with the HIV epidemic, it has been one of the sources of coverage for people with HIV AIDS and today covers about 44-percent of the individuals living with HIV AIDS. And as I said a major source of help for people in nursing homes, accounting for about 65-percent of the

nursing home residents although they continue to have to spend down and contribute toward the cost of their care so it is not their full care that Medicaid is actually picking up.

It is a program that is a joint partnership between the federal government and the states and as I said the states do have latitude over how they cover certain populations, what optional benefits, optional populations they wish to cover in their programs and still receive federal matching funds for them. And as you see from this slide, the percent of non-elderly residents covered by the program varies widely across the country in part shaped by which states have higher concentrations of poverty and in part shaped by the eligibility rules and choices different states have made.

Now, when we think about Medicaid, I think this is perhaps the slide that you should take away with you for the most in depth understanding of the way in which this program is structured and how it actually operates. As I said, half of its enrollees are children yet they account for only 18-percent of the program spending.

So adding more children through an expansion of Medicaid and SCHIP is not going to increase substantially the spending under Medicaid in comparison to what it does to program spending when you expand coverage for people with severe disabilities or for the elderly who account for as you can see 70-percent of overall spending in the program.

And you can see the difference here very clearly when you look at the fact that the per capita spending on children and adults is far lower than that for the elderly and disabled but I would just point out that acute care spending for people with disabilities is the highest part of their spending so it is not just Medicaid's long term care role that creates this inequity.

When you look at how the eligibility rules work, you see here again what drives more children onto the program and fewer adults. The states have been given much more latitude through Medicaid and then through the CHIP program in combination and now many cover children at or above 200-percent of poverty with the median coverage for children at 200-percent of poverty, pregnant women closely behind.

Whereas those who qualify through their disability or through being on the supplemental security income program, the cash assistance program for the aged and disabled, the median income is about 74-percent of poverty and for working parents it is much lower for childless adults, does not even cross the threshold because they are not eligible unless covered by a waiver.

And I would remind you that poverty is a very low income, it is $21,200 per year for a family of four in 2008, $22,000 this year, so we are talking about individuals with very few resources which helps to explain why the benefits in

the program tend to be comprehensive and the cost sharing levels tend to be very limited.

Again, this just really captures the fact that there is such substantial variation in coverage for children and you look at the wide range of incomes covered across the country and you see that in 17 states, in 11 states in D.C., children over 250-percent of poverty are eligible for the program today.

And in stark contrast you see that only in 18 states parents are covered only below the federal poverty level and 18 states are covered at or above the federal poverty level, I'm sorry, but in 13 states they are covered below 49-percent, below 50-percent of poverty, less than $11,000 for a family of four. So one of the key issues in the program has been how do you bring better adult coverage levels up so that they begin to provide at least fuller coverage for families?

So, in conclusion, I would say that in terms of being on the front line in health care reform, Medicaid has played and continues to play a substantial role in coverage of low income adults and children, doing better by children although there are still outreach and enrollment problems that many children who are eligible for the program are not participating.

One of the goals of the new legislation extending SCHIP is to try and promote better enrollment practices to help get more eligible but unenrolled children covered, so that is the

challenge for low income children. But for parents and for adults without children it really is getting the eligibility levels up so that they can be covered and for adults without children looking at ways to get around or remove the categorical restriction to move the program toward a more income related program and less of a categorical program.

So, those are some of the challenges and structural issues in the program as it moves forward as both a health a long term care program for our nation's lowest income citizens and others.

ED HOWARD, J.D.: It is a terrific foundation, thank you, Diane. By the way there is a sheet in your materials; it is a salmon colored sheet, if you have the hard copy, that details the 2009 poverty guidelines from HHS.

Now, we are going to hear from Barbara Edwards. She is a principal with the national research and consulting firm, Health Management Associates. She ran Ohio's Medicaid program for eight years. That is a $12 billion a year operation. She has been nationally recognized as a leader among Medicaid administrators for years and I am pleased to say she has graced more than one alliance panel over that time.

Today, she is going to concentrate on Medicaid financing and on the state responsibilities for the program. Barbara, welcome back. Thanks for being with us.

BARBARA COULTER EDWARDS, M.P.P.: Thank you. It is wonderful to be here and it is always wonderful to see the size of the audience for these conversations. Medicaid is a wonderful program. It is a complex program and it is central to so many solutions that we look to government to deliver and in fact is increasingly a program that has a big impact on the private sector as well.

I want to start in describing the state role in Medicaid by emphasizing the fact that Medicaid is a partnership program. It is a state federal program. You have heard from Diane there are federal parameters within which states administer the Medicaid program. There are state federal mandates for coverage, for benefits and there are parameters for how states pay but states have a great deal of discretion with regard to some optional services, optional populations, the design of the delivery system and reimbursement.

States buy in the general health care marketplace. This is not like the VA system where there are special hospitals or clinics built to serve the population. Medicaid consumers are consuming in the general marketplace and Medicaid therefore interacts with that marketplace.

Because states have some discretion around the design of the program, states file a state plan with the federal government, with the centers for Medicare and Medicaid services and health and human services. The state plan defines,

describes how the state is going to manage the program. It commits the states to the mandatory activities under the program and it also outlines the optional choices the state has made in terms of running the program.

The secretary of health and human services has to review the state plan and any state plan amendments, actually CMS handles that for the secretary. The secretary also has the authority to waive many of the regulations and provisions of the Medicaid program to let states manage the program in ways that are outside the specific federal parameters.

You hear a lot about waivers in the Medicaid program. They are a very important mechanism for design of the program. I am not going to talk a lot about waivers today unless somebody asks the question. What is important is that once a state has an approved state plan or has approved terms and conditions with regard to any waivers, those become binding on the state in terms of running the program. It is an entitlement program for the folks that are described in the state plan.

I was asked to speak today about how states finance Medicaid and I was inclined to tell you that if I told you I would have to kill you. But it is actually a little more straight forward than that, despite some of the press that states get around financing. States pay for services for

Medicaid and receive reimbursement from the federal government for a portion of those service costs.

The federal medical assistance percentage is the FMAP describes the percentage of the federal share and it is specific to each state. The FMAP is a minimum of 50-percent and ranges up in 2009 the state that had the highest federal share of the program was Mississippi at 75.67-percent.

The FMAP varies based on the relationship of a state's per capita income to the national per capita income. It is adjusted annually. It is based on prior years rolling experience. It is one of the challenges states have with FMAP because the FMAP you have today doesn't reflect what is going on in your state today with regard to per capita income.

It reflects what was going on, on average, in recent years. So, it means that it doesn't change very quickly to reflect what may be happening in the current marketplace, but this is a long standing formula for the termination of FMAP.

The FMAP for administrative costs which are very low in the Medicaid program, states run Medicaid for about 3 to 5-percent of the total program costs. The federal share of administrative costs is set at 50-percent regardless of a state's per capita income and there are some enhanced percentages around the development and operation of the information systems that support Medicaid.

The picture here, the map shows the different FMAP percentages for the various states and as you can see the states in white are the states that are getting the 50-percent FMAP. They are relatively higher per capita income states and the states that get progressively darker as states are poorer and they get much higher rates of federal match.

Now, when states buy Medicaid services, they have to put up state dollars and then get reimbursed and the source of the financing at the state level is also relatively straight forward except that it is in the tax codes and there is almost nothing straight forward about tax codes.

States finance Medicaid out of appropriations from state or local general revenue funds and that is the bulk of the way that most states identify the dollars that are spent to support the Medicaid services. There are also defined in federal law and regulation permissible health related taxes that are used in most states to raise additional revenue to help finance Medicaid and this would be a tax.

For example on hospitals in the state, the state collects the revenue from the hospitals, they use that revenue in funding the Medicaid program, and those tax dollars then become eligible for federal matching funds or taxes on nursing homes is often a common provider tax. We hear a lot about this.

There are federal regulations about permissible use of those taxes. It is basically about being sure that the taxes spread broadly across all providers of similar type in the system and that no provider gets an absolute guarantee that 100-percent of their tax dollars will always be refunded through Medicaid reimbursement.

Other ways that state fund Medicaid, again generally out of general revenue funds, is through things called intergovernmental transfers and certified public expenditures and what this really means is that sometimes the appropriation rather than going to the Medicaid agency, goes to a sister state agency, say the Department of Mental Health or the Department of Aging.

Dollars from that system can be transferred into Medicaid to buy services under Medicaid and be matchable or it might be a transfer from a public hospital in the state and then certified public expenditures means that a public provider has spent money for an allowable Medicaid consumer for an allowable service and they can certify that they have spent those dollars and then the state can file a claim with the federal government for the match rate. These are important mechanisms in the state but they basically all come out of the states' tax base one way or the other.

Medicaid is a huge challenge for states when it comes to budgeting. The major reason it is a huge challenge is that

it is a huge part of every state's budget. It is on average about 22-percent of total spending in state budgets. It goes head to head with primary and secondary education as the single largest item in a state's budget. States make a massive commitment to the Medicaid program.

The challenge for Medicaid is that because Medicaid costs typically grow faster than state revenues grow. Medicaid over years tends to crowd out other priorities in state budgets. States have to balance their budgets every year so they don't get to sort of average it out over a period of time or borrow funds and hope somebody in the future is going to be able to figure out how to pay for that, they have to balance it every day.

So, if Medicaid dollars are growing, spending is growing faster than the state revenues, Medicaid takes up a bigger space in the state budgets and crowds out other priorities. Medicaid grows because of medical inflation which grows faster than the general economic growth in the country because we have an aging population and as we get older we use more health care services, and because of policy changes.

We actually deliberately grow Medicaid to add more people to the coverage or to put new treatments on the program. Sometimes we grow Medicaid in response to specific congressional opportunities to use Medicaid in broader ways, so it is – and the biggest reason Medicaid can grow and create a

problem in the short term is because Medicaid is designed to be countercyclical.

When I say countercyclical, I mean this. Because Medicaid is an income based entitlement, when the economy declines, and unemployment grows, people who have looked at this have said that 1-percent increase in unemployment translates into a million new people enrolled in Medicaid and the SCHIP program at the state level, which in turn translates into $3.4 billion in additional spending, state and federal, even as the states revenues are dropping because of the increase in unemployment.

And when you look on the next picture, you will see what the country looked like in the last recession. The yellow bars show the states' revenue change from year to year. From 1997 to 2006, you can definitely see a recession taking place there. And the red bar shows the increase of Medicaid spending from year to year during that same ten year period. This is the countercyclical nature of Medicaid and it is why the governors get a little worried when the economy drops.

So, states have a challenge to control Medicaid spending. In the short term, the challenge is balancing the budget within the 12 months of this budget and states really only have three options for doing that. You can restrict who you cover within the optional populations.

You can restrict the optional benefits or you can restrict what you pay providers. And when you look at the last recession, particularly 2003 and 2004, what you see is that states did everything that they could do during that period to try to slow the rate of growth in Medicaid so that they could keep it within the bounds of a balanced budget.

You will notice that in fact almost every state undertook efforts to control the spending on pharmacy, 100-percent of the states cut or froze provider reimbursement and that half the states in 2003 and almost half the states in 2004 actually did restrict eligibility and almost as many states restricted benefits during that time period.

When states look at Medicaid costs out into the future, the cost containment challenge looks a little different. This shows a projection by CBO that Medicaid's total spending state and federal dollars will increase to $736 billion by 2017 which is a doubling of the program spending from 2007. So when states look at this, they are trying to figure out how actually to bend the trend in Medicaid growth from year to year, not balancing the budget just on a year to year basis, but actually slowing the rate of growth from year to year so that total spending on Medicaid becomes more manageable.

These are longer term strategies that involve more reforms to how health care is delivered, to how coverage is designed, to the nirvana of health care consumer behavior and

how that contributes to the cost of health care, and trying to slow the erosion in the private dollars in health care so that fewer people would be falling into Medicaid coverage.

The final point I will make is that Medicaid buys in the health care market place. It is not a system that can be managed in isolation of what is going on in the larger health care arena. It impacts the larger market place but it is also impacted by it and it is not - while it is a large buyer, it is not large enough to totally control what is going on in the rest of the health care delivery system. It has got to be a part of a larger context. Thank you.

ED HOWARD, J.D.: Thanks very much, Barbara. And our final speaker is Dr. Andrew Bindman. Andy is a professor of medicine and health policy, among other topics, at the University of California San Francisco. He is a primary care doc. He runs the California Medicaid Research Institute. And today he is going to concentrate on Medicaid's impact on access to care as well as some of the service delivery and provider payment issues that you have heard touched on already. Andy thanks for being with us.

ANDREW BINDMAN, M.D.: Well thank you. It is a pleasure to be here. And, I am already relieved by one thing I heard. Barbara said that states have to balance their budget each year, so being from a state that is challenging that

concept, I am glad to hear it will end by the end of this fiscal year. [Laughter]

So, I am going to try to talk a little bit about from the perspective of what goes on with regard to the importance of Medicaid as a program to divide access to care and we will speak about. So, you have heard some reference to this today in Diane's part of the talk but this sort of gives you a little bit more of a granular feel for where Medicaid is spending its money.

If you look at this pie chart as being the total of $304 billion spent in 2006, you can see that a little over 58-percent or the kind of yellow line shaded part of the pie is for acute care services. That is things like in patient hospitalizations, payments to physicians and to laboratories and for diagnostic x-rays, 6.8-percent out patient clinics, 5.5-percent for medications, and also 18-percent you can see at bottom two managed care organizations which I will come back and talk a little bit about later on.

About another, a little over a third of the spending in Medicaid is also spent on long term care and Diane referred to that and again it is something to emphasize that many people don't necessarily first think about Medicaid as a program that is supporting long term care. I think a lot of people get confused between Medicare and Medicaid, thinking Medicare is

for the elderly, well in fact it is Medicaid that plays such a significant role in long term care in the way that Diane alluded to in her comments.

And, this is in nursing home care services, in home and community based services to keep people in their homes who need additional support and a variety of other programs for people in intermediate care facilities and people with chronic mental illness and the like.

Barbara just touched on the fact that Medicaid purchases in the general market place and this just gives you a sense of what kinds of services Medicaid is purchasing. If you take a look on the left hand side, you can see that Medicaid is buying about 16-percent of services in the market place as a percentage of total health services and supplies.

Hospital care, they purchase about 17-percent in the United States. Professional services, which include things like payments to physicians, is 13-percent. Nursing home care is where its biggest purchasing clout is in nursing homes is 42-percent, and prescription drugs 8-percent of the U.S. total.

There are ways of trying to gauge how important Medicaid is as a program to provide access to care. I am not going to be able to provide you with all of that today, but this just gives you one glimpse into that and the take home message here is that Medicaid is extremely important and in fact it probably provides for many of the vulnerable patients

that you have heard about, access to care that is much more comparable to the private insurance market than it is to those who are uninsured.

And so if you look at and this is broken out by adults and children, one important measure of access to care is whether someone has a usual source of care. You can see that among adults, 52-percent of uninsured persons have no usual source of care whereas 10-percent of those in the Medicaid program and 10-percent of those who have private insurance report that phenomenon so Medicaid looks very similar to private insurance in that context.

Similar comparison there for children with regard to no usual source of care, children are a little bit more likely than adults to have a usual source of care but again Medicaid looks more similar to private insurance than it does to the uninsured and that really shows you the important role it plays because if people who are eligible for Medicaid were not getting Medicaid, in general they would be uninsured.

Another measure is whether people had needed care but they did not get it. Again, what you see is that Medicaid has a profile of individuals reporting that, that it is much more comparable to those with private insurance than it is to those who are uninsured, although there are some small differences.

The adults, a slightly higher percentage of those on Medicaid do report this difficulty compared to adults with

private insurance. So I am not trying to say that it is exactly comparable to private insurance but I would say on the spectrum between private insurance and uninsured that Medicaid comes out much closer to private insurance than it does to those who are uninsured.

What I want to talk about a little bit is picking up where Barbara just alluded to, some of the challenges in state budgets is to think about what impact those – what state budget challenges will mean in terms of potentially undermining access to care for those on Medicaid. And, in particular I want to comment on issues raised about whether challenges in state budgets might result in reductions in provider payments, reductions in enrollment in the program, and the use of managed care in Medicaid.

This comes from the reliable medical reference of *The New Yorker* who makes the general comment is there a doctor who accepts Medicaid in the house? And this is a cartoon that didn't just come out this year. It has been around for a long time. There have been issues for a long period of time about whether there are sufficient numbers of providers participating in the Medicaid program and this gives you some sense of the trend with regard to that.

You can see on your left hand side that when surveyed, physicians report that among those who will say they will take all new patients, only about 50-percent say that to be the case

for Medicaid and that was true in 1996 and it is essentially 52-percent in 2004 and 2005 when they were resurveyed.

That, in contrast to physicians with regard to taking only patients who are either privately insured or who are covered by Medicare, the program for those over age 65, and you can see that many more physicians are open to taking new patients with that type of insurance as compared to Medicaid.

Switching over to the right hand side of the graphic, you can see that if anything, over time there has been a slight uptake in the number of physicians reporting that they are taking no Medicaid patients at all in their practice so it is up to 21-percent in 2004, 2005, nationally. Again, if you look at private or Medicare, it is in the single digits the number of physicians who would say that they would not take any new patients, either with private insurance or with Medicare insurance, so getting physicians to participate in this program is a challenge.

I want to make sure you understand that physicians' participation in Medicaid is voluntary. They are not required to take Medicaid patients and some of the reasons that physicians cite for why they do not take Medicaid patients in their practice have to do in part with some of the characteristics and complexities of the patients in terms of the challenges they may present in an office based setting.

There are long standing statements made by physicians about their concerns about being sued, although I want to say that there is a significant amount of data to suggest that this is actually an unfounded myth in the sense that many on Medicaid probably sue at a significantly lower rate than those in the general population but it is a concern out there among providers in terms of why some say they don't take Medicaid patients.

And then administrative hassles and payment delays, the challenges of filling out extensive paper work or the delays in getting payment from Medicaid have left many private providers saying that they don't want to do it to the extent that there are many physicians who report that even when they take Medicaid patients, they don't go through the exercise of actually billing for it because of the hassles or delays of getting paid.

The strongest predictor, however, of whether a physician will participate in the program has to do with the state payment rates and states do get to determine what they want to pay in the Medicaid program to providers.

One way that this is described when looked at across states is a payment relative to the amount that is typically paid for a Medicare patient in the state and so that they will often see the Medicaid, the Medicare payment ratio for providers. And on average across the United States it is about

70-percent payment for Medicaid as compared to what the Medicare payment is in that state.

This just gives you some feel for what I am describing in terms of participation rates of physicians in relationship to the payment rates in different states. Nationally, about 62-percent of all physicians were accepting of Medicaid patients, but if you look at the low fee states, that was only 52-percent of physicians versus the high fee states, about 68-percent of physicians.

So some real differences there related to the payment rates and you can also see that it differs a little bit between primary care and specialist physicians where specialist physicians are a little bit more likely to have some Medicaid patients in their practice compared to primary care physicians but again that same differential between low fee states having lower participation rates compared to higher fee states.

I am going to transition a little bit now to talk about some of the issues related to eligibility. One of the things you need to understand about the Medicaid program as an entitlement program is that any person who meets Medicaid eligibility is entitled to the benefit. There is no wait list if you will for the service. Now, to do this determination of eligibility, the federal requirement is that this be done at least on an annual basis.

However, states do have the discretion of deciding to do that more frequently if they deem that to be what they want to do in that state and many states do in fact do it more frequently. And the one thing that is clear from this however is that the frequency of determining eligibility and the ease of that process within a state will affect the number of potentially eligible beneficiaries who end up truly being enrolled in the program who will experience gaps in their enrollment.

This comes from some work that we have looked at in California where in fact there was kind of a natural experiment in our state where the requirement for demonstrating eligibility among children in California was changed in 2001 from a frequency of every six months to a frequency of every 12 months. And what happened during that time period was that there was a significant increase in the percentage of children from 49-percent to 62-percent who had continuous Medicaid coverage throughout the year.

They did not experience gaps in coverage and it has been shown nationally that these gaps in coverage are typically of two to four months in duration and that they are not generally the type of gaps that you would typically see related to market fluctuations in the income of a family, but are probably most likely seen in association with kind of the

administrative challenges that can come up with maintaining enrollment in the program.

We further have looked into this in California to see what kind of health impact does it mean for a beneficiary if they have a gap in coverage? And we looked at hospitalization rates for conditions like asthma and diabetes and congestive heart failure, things for which hospitalizations are viewed as preventable because in fact we have many good out patient treatments for those conditions and along the bottom.

The orange bar are those individuals in California who had continuous coverage over a five year period and what their rates of hospitalizations were for these preventable conditions over the five years. And you can see that the probability of hospitalization for those conditions was about 2-percent among those with continuous coverage whereas those in the yellow line, the interrupted, those who had gaps in coverage, experienced dramatically higher rates of hospitalizations for these conditions when you track them out.

And typically it is in those first few months after losing coverage that someone would be much more likely to have a hospitalization for a preventable condition that could generally be treated in the out patient setting but because of the lack of coverage, often are not getting medications to maintain their health and the like, becoming sicker and

resulting in a hospitalization and a more costly part of the health care system has to step in to take care of people.

Finally, I want to just draw your attention to the fact that the Medicaid program is delivered through Managed Care in the majority of most states. That isn't to say that every beneficiary in all those states is in a managed care program but in most states managed care is being used for at least some or a substantial number of Medicaid beneficiaries.

The benefits ascribed to this delivery model have to do with the potential to try to improve access to care through the requirement of a beneficiary having a primary care provider and I want to emphasize that because the fee for service delivery model of Medicaid has not traditionally had a requirement that an individual have primary care medical home, or a primary care doctor.

And so there are some real opportunities through things like managed care to in fact get a beneficiary connected with a primary care home that can help do prevention and education to help people stay healthier which is obviously one of the real goals of the health insurance program.

There are some concerns that are raised about the use of managed care as a delivery model that managed care in general has been talked about as something that might limit access to high cost services like specialists. And so that there is on the one hand some arguments about the benefits of

Medicaid managed care as access to primary care but some offsetting concerns by others that in fact it may be used as a tool to try to contain costs.

I will say that as states look at ways of trying to find more efficiency and value for their Medicaid dollars, that there are discussions underway in many states like California to expand the use of mandatory Medicaid managed care for a larger proportion of their beneficiaries in the hope that this would be ultimately both a good way to provide access and to be a good value for the Medicaid dollar.

I thought I had one other slide, but I guess it maybe got cut off which was a state slide. I have it on my handout, but it is not there and it should be in your handouts which shows the national picture of the country and the relative proportion of Medicaid beneficiaries in Medicaid managed care in those states so hopefully you have that, at least in your handout, and you can see the relative penetration in the different states.

It is missing from the handout as well, I apologize. I will try to make up for that, but it does vary across the country. I guess I will just sum up by saying that Medicaid is an extremely important program with providing access to care for some of our most vulnerable individuals in the country and it is also a program that because of the financing that was described by Barbara, there are challenges that can undermine

the ability of the program to maintain access and this is something that is going to require careful attention as policy decisions are made going forward. Thank you very much.

ED HOWARD, J.D.: Thanks very much, Andy, and we will make sure that we post that unseen slide on our website and it will be on kaisernetwork.org as well. Now, we get a chance for you to ask the questions that have been raised by the presentations or by the gaps in your own knowledge or what we chose to cover in those presentations. You have three microphones in the audience.

I would urge you to use those microphones, try to be as brief as you can with those questions, you don't have to be simple, you don't have to be complicated, but we would ask you to be brief, identify yourself.

Those of you who are in the state and district offices, let me just remind you, if you want to submit a question by e-mail, if you will go to the Alliance website, allhealth.org, the top item is about this briefing and if you click on the read more button there you will land on a page that describes the briefing and shows you exactly how to send an e-mail to ask a question.

So, we will start first with the folks who are lined up at each of the microphones and that gentleman was the first person at any microphone.

JOE HUNTER: Joe Hunter, Senate Help, basically the flexibility of the state Medicaid programs can be a great source of experimentation. At the same time, there is a blizzard of eligibility rules that nobody can understand. If you are a patient living in that state it is very difficult to understand them.

There is no one at the federal level who seems to understand this. In fact, there is a national Medicaid expert who says there is no such thing as a national Medicaid expert. It's all at the state level, and then certainly for anyone trying to do cross state analysis.

Given that, is there any type of consensus that you guys are thinking about in your back room discussions with each other about how to simplify and streamline while at the same time preserving some of the flexibility that gives rise to experimentation?

BARBARA COULTER EDWARDS, M.P.P.: I'll start. We used to say that federal and state agencies would have to go find the one person at the federal level that understood the rules and the one person at the state level who understood how the state had put it together and let them talk about eligibility. It is enormously complicated. It is probably the single biggest challenge of the Medicaid program.

It is not that it is a program for low income people. It is a program for people who fall into a set of boxes. I

think there are over 50 federally defined eligibility categories, plus states have options and even within those categories, states can decide how to count income and assets and all sorts of things, you are right, it is enormously complicated and I think it is a big challenge for the program.

It is also how the program has been so flexible to solve so many different kinds of problems. But, states have for many years been saying that they would like to see more simplification around the eligibility program. The challenge of course is they don't really want someone else to tell them how to do that. There are some states that are trying to experiment with simplification.

Wisconsin I think is a state that has worked really hard at filing a series of waivers to try to find a way to make eligibility an easier concept in their state. One of the proposals that comes forward from time to time from various groups has to do with making Medicaid just a single income base, that everyone under poverty was covered by Medicaid, that would be a lot easier to understand, so there are ideas out there about how to do it.

The challenge is that applying any new definition to all of the existing programs creates winners and losers and there is always the fear that some states would have to spend more money if you went to a new standard and some states would be concerned they would lose the ability to cover some of the

people they currently cover, but it is an area that, I don't think you would get any argument from states, deserves attention.

DIANE ROWLAND, Sc.D.: I think it is also an area if you look at the policy toward children, we have moved toward trying to get to at least a more standard base, even though you give states the flexibility to go above that with higher incomes so that all children under poverty must be covered or must be eligible for Medicaid.

So, I think in looking at the way you simplify the program, you have this hard choice of where do you draw the federal minimums to make everything the same across states and then where do you give states the flexibility to go above that and do more, but as Barb said there is always a pension when congress looks at it to keep these groups grandfathered who were once covered. And I think one of the real challenges in going forward is to say in the effort to make this fair and simple, we may have to get rid of some of what we call these grandfathered groups.

ED HOWARD, J.D.: Let me just say, by the way, I did not mention again that you can if you do not want to go to a microphone fill out a green question card, hold it up and someone from the staff will bring it forward. Yes go ahead.

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health, all of the speakers have talked

about how the Medicaid program really just purchases health care in the market place and it represents only a sliver of that market place, maybe 20-percent.

In previous briefings, we often hear about different degrees of inefficiency in health care delivery systems. For example, the Dartmouth Atlas shows tremendous variation, sometimes as high as 500-percent between some states and other states in the utilization of Medicare services.

I am struck by the lack of options that the states have in being more efficient in the way they use their Medicaid dollars. They can challenge, they can restrict the eligibility, they can restrict the reimbursement level, and they can restrict the benefit package themselves, but I am wondering. It seems like the Medicaid program is the most significant liability that the state faces for having an inefficient health care delivery system.

In the 60s and 70s after Medicare and Medicaid were developed, the federal government was interested in health care planning processes in order to avoid inefficiencies in health care delivery. We had certificate of need processes and state health plans.

I am wondering if there is any effort on states' parts to expand their community health planning mechanisms so that the entire health care market place that they purchase in is more efficient, effective and equitable? That is not an option

I often hear talked about as a strategy for dealing with rationing health care services and yet it seems to me the most useful one for states to be thinking about.

ANDREW BINDMAN, M.D.: Yes I think it is an excellent comment. I will just speak a little bit to what I observed in California with regard to this, which is that I think many states if they are like California suffer from the lack of the kinds of data that they need to be able to make good value based purchasing, to know about quality of care, the kinds of data systems that are structured in many Medicaid programs follow very traditional fee for service type models of a service was done, we are going to pay for it with very little ability to judge the quality of the service that was delivered.

I think some of the attractiveness of managed care organizations for Medicaid, at least again in California, has been that at least in managed care there has been some development of accountability measures like HEDIS and so forth, to try to make judgements about the quality of care and there is some activity going on in many Medicaid managed care plans in different states to try to incentivize on the basis of some of those kinds of HEDIS measures or things like that.

In general, I think your point is exactly right, that it is a much more productive way to think about looking at the financial challenges to combine it with information about quality so that either selective contracting or different kinds

of methods can be used based on purchasing quality that will be important.

But I think Medicaid programs have a long way to go to revamp their data systems to allow them to have the information they need to be able to do that kind of work and I would be interested to know about states that are doing a good job at that. I think we are still at a very rudimentary state in my own back yard.

BARBARA COULTER EDWARDS, M.P.P.: I would only add that I agree with everything that Andy said but it is a political environment and every Medicaid dollar that is spent is somebody's revenue. So, it is extremely difficult to restrict where the public dollar is going to be spent when those local providers that are often the largest employers in local communities take their case to the legislature as well and to the administrations in states.

So I think the issue, you need real power behind the information on which you would be making those kinds of decisions and I would agree that right now a lot of that information is pretty lacking.

STUART MULLER: I am Stuart Muller with American Fathers, we represent a very large number of unwed fathers and low income families, low income divorced fathers who are ineligible for Medicare or Medicaid, mainly because of their custodial status. Is there any effort under way to recognize

these parents and to make an outreach to them so they can become covered, and if not, why not?

BARBARA COULTER EDWARDS, M.P.P.: You know, I think you raised a really good point. When we talked about Medicaid as not a program for people based on income, it is based on whether or not you fall into one of the many categories of eligibility and non-custodial parents is not one of those boxes that is defined in the federal law with regard to eligibility.

Some states have made some progress at covering adults who do not have dependent children through waiver programs and other kinds of strategies to try to expand coverage generally to low income workers but I am not aware of states that have reached out specifically to non-custodial parents.

I think states are more often looking at the broader issue of can you reach uninsured adults who don't have dependent children? And I think there is a lot of interest in that issue for states.

CHRIS JACOBS: Chris Jacobs with the House Republican Conference, during the debate on the stimulus bill, there was a provision in the house passed legislation, it was not in the final conference report, to extend Medicaid to anyone receiving unemployment compensation regardless of income or assets, at the Energy and Commerce Committee mark-up, republicans offered an amendment to cap an income cap to limit eligibility for Medicaid to those making under $1 million so some of the fired

CEOs that helped cause the current economic crisis would not be eligible. [Laughter]

Chairman Waxman surprisingly opposed this measure and it is interesting the reason why he said. He said I think it is highly unlikely that you are going to find millionaires who would like to go on Medicaid. So do you agree with Chairman Waxman's comment that millionaires would not like to go on Medicaid even though it would be provided free?

Why might he say something like that and if it's unacceptable for millionaires to go on it and they would not want to go on it even though they're getting it for free then why is it a good form of coverage for 60 million low-income and vulnerable Americans?

DIANE ROWLAND, Sc.D.: Well clearly you pose a very interesting dilemma as one looks at Medicaid eligibility and who would enroll. What we know is that the process for enrolling is not always the easiest process. So I think one could easily think that while low-income families are used to going through the application process, showing their paycheck, showing their documentation for eligibility that others who have lived a different kind of life may not be as anxious to do that.

What we have found in some focus groups that we've been doing around the country is that there are many people who have recently lost their jobs, lost their health insurance coverage,

are ineligible for the COBRA extension perhaps because they didn’t even have health insurance through their jobs before, who are coming to Medicaid and applying and finding out that just their very unemployment check puts them over the income eligibility levels for the Medicaid program.

So I think there are serious problems in terms of using this program as a stopgap unless you do open up the income ineligibility levels for a short period of time to let people on.

We found in one of the waivers that was enacted right after 9/11 in New York that there was the same criticism that everyone was going to start applying for Medicaid because it was opened up without any requirement for a severe income test and yet the people that applied tended to be the people for whom Medicaid was more a part of their life, food stamps, Medicaid, other things.

So I think there’s an expectation that if you opened it up, you’ll get millionaires on the program but I think the reality has been that millionaires usually have other choices than people who are moderate income and modest income individuals. I think when you open up the program also, you see the kinds of issues that Andy Bindman has talked about in terms of access. So we do know some of the problems with the Medicaid program are that we give people eligibility to the program but they may have difficulty maintaining their coverage or are

finding a doctor who'll see them. So I suppose the other comment would be millionaires maybe have a different set of providers that they're used to going to than those that accept the Medicaid program.

BARBARA COULTER EDWARDS, M.P.P.: Just one follow-up comment. I would say that when people have disabilities or have family members who have a really serious disability, there's a pretty strong interest to getting access to Medicaid coverage for people t much higher incomes than poverty. So again, I think it is a strong program in terms of it providing benefits that are not generally available otherwise and that for children with disabilities.

Families can have pretty strong incomes and be working very hard in their states to get Medicaid expanded to allow their children access to those long-term care services and supports that private coverage doesn't provide. Those millionaires' grandparents might be having Medicaid coverage if they're receiving long-term care services. So I think again, Medicaid is many programs and the public, general public, reacts differently to different pieces of it.

ED HOWARD, J.D.: Yes go ahead please?

SUELLEN GALBRAITH: Suellen Galbraith with American Network of Community Options and Resources. We represent providers of support, community living and employment support. I'd like to go back to the issue of reimbursement and ask what

are the requirements in the Medicaid statute regarding reimbursement rates and particularly focused on one that is a real issue right, now prompt payment.

I think Dr. Bindman, as you well know, in California when there was, the legislature failed to come to budget agreement last year, last summer, providers, under the state law, could not be paid and that meant that many of our members in California, and they were mostly non-profits, were not able to be reimbursed for several months.

So the prompt payment issue and then you move into a very economically challenged or recession, that becomes an issue. I know that was addressed a little bit in the recovery package but I think it's been pulled back to just refer to hospitals and nursing homes, the prompt payment requirement.

BARBARA COULTER EDWARDS, M.P.P.: This is an issue that, as you point out, your question combines a lot of different situations. One is what do states do when they literally have no cash and sometimes what states choose to do then might not be what they would argue is their best policy but it may be what they can do.

I know in my state, if there are state-specific laws with regard to prompt pay for all government payers, not every state has that or it might not apply to all contractors but in my state, if we got to the end of the year and we're a little tight, trust me, we paid very close attention to whether or not

holding up a check would cause us to trigger the penalty, interest penalty, that we would owe if we paid outside of 30 days.

So that can vary at a state level with regard to policy. At the federal level, there are some requirements around prompt pay with regard to Medicare plans, managed care plans but I think that for the most part, those issues are really state-level issues in terms of how the state government relates to its obligations.

SUELLEN GALBRAITH: But there are requirements regarding reimbursement setting in general.

BARBARA COULTER EDWARDS, M.P.P.: Oh with regarding reimbursement in general, yes. There are, and again, they can vary by the type of provider, type of service that's being delivered. Some services, for example hospice services, if the state chooses to offer hospice, they have to use the federal reimbursement and the federal definition.

Certain hospital outpatient, lab services have to use the Medicare schedule. Other services, states have HMO. If you have a managed care plan, the federal law says that the rates have to be actuarially sound. It doesn't say exactly what that process is but it says it has to be actuarially sound. Other rates have to be, I think, consistent with efficiency, economy, and appropriate access to care.

So again, it tends not to be a very rigid federal standard. It tends to be one that gives states considerable discretion in figuring out how to assure appropriate access in their state within their resources. States obviously would argue that that's the way it needs to be.

SUELLEN GALBRAITH: Thank you.

ED HOWARD, J.D.: Before we take another question from the microphone, we've got a bunch of green card questions. We're probably not going to get to all of them or it's going to be difficult. So I urge you to, if you're really impelled to get an answer, to go to a microphone. Diane?

DIANE ROWLAND, Sc.D.: This question, Andy maybe goes best to you since Medicaid participation by health care providers is voluntary, are there strategies that states can use to ensure that there are enough providers for all eligible Medicaid beneficiaries?

ANDREW BINDMAN, M.D.: I think it's a great question about how states can try to encourage providers to participate. I think there are some clues from some of the things that we've learned from focus groups and surveys of doctors. So some of it has to do with the last question about the delays in payment and attending to administrative hassles with regard to payment. States will vary tremendously with what the makeup is of their provider network.

In some areas there's a lot of focus on investments being made and working partnerships with community clinics and other sites that may take on a large proportion of the Medicaid population and to try to work effectively to either create rates that are workable in those settings or have other kinds of infrastructure supports.

The biggest thing I guess I'll say is that if you look at kind of why participation drops off, it kind of happens in these, there may be sometimes that there are kind of dwindling participation rates but we see steep drops when we have things that are going on now. That is if there are either freezes or more dramatic, as was proposed in California, rollbacks in payment rates, I think this sometimes provides a window in which providers sort of feel like they've crossed over a line and may not be willing to then stay involved.

Even if those things are made up for over time, it's very hard to re-engage those providers back and so that you're sort of waiting for a new generation of providers who maybe didn't experience that. So I think it's very harmful in terms of these fairly dramatic things that happen economically that may lead to results like rolling back on payments that you could then shed a very large number of providers. I think it's something we need to pay careful attention to right now.

Those numbers that I showed you in my talk were from a couple of years ago. I would not be surprised if certainly

anecdotally our sense is, in California where rollbacks were proposed that there may be more providers dropping out. So I think providers look for consistency in terms of their relationship with a payer.

ED HOWARD, J.D.: Barbara, do you want to add?

BARBARA COULTER EDWARDS, M.P.P.: I want to just add that there are some challenges that are bigger than just sort of can you get a decent rate out there. There are some specialties, for example, where there just appears to not be enough to go around to meet the need. As those providers, whether it's psychiatric providers or in some cases it might be dental providers, where there's a pretty strong control over who's getting into the market to sell those services, I think there's a sense of that with dental.

To the extent that providers have the ability to sort of not deal with any third party payers, we see some providers who sort of remove themselves from being available even if, in fact, they might not even want to see the Medicare patient or maybe a Blue Cross patient. So there are challenges.

The other challenge that Medicaid deals with is that where the patients live and where the physicians have their offices may not be in the same place. So you may have lots of docs in the suburbs and they may not be seeing a lot of Medicaid folks but even if they open their doors, you may have

a lot of the people that have Medicaid coverage not be able to access geographically those services.

If the hospital pulls up stakes from the inner city and moves out to where the population is growing and has better private coverage, again, you have a real challenge with access potentially for some populations.

So those kinds of issues are also need to be taken into consideration when you're thinking about what those challenges are. There are both structural and reimbursement and even cultural issues where some doctors are very committed, some providers very committed to mission in terms of service and others may feel less of a commitment to serving indigent populations.

ED HOWARD, J.D.: Go ahead.

PHIL SARNOWSKI: Good Afternoon. I'm Phil Sarnowski with Booz, Allen, Hamilton. Some of the discussion so far has hinted at looking at other states for best practices and conducting the program. My question is and for the whole panel but I'd be interested to hear what Barbara Edwards has to say about how much collaboration actually formally exists and informally exists between states?

When you were running the Ohio program, how often were you influenced by what other states were doing not just in terms of enrollment but in terms of staffing the program and all aspects of spending within the program? How much are other

states learning from other states and I guess, for the entire panel, is this something we can do better?

BARBARA COULTER EDWARDS, M.P.P.: Well I'll start since you asked. I think states are very interested in how other states are doing Medicaid business. I think one of the reasons that one of the Kaiser surveys that HMA has the privilege of helping to pull together on the state budgets because it's done every year. States eat that up. They can't wait to find out how their policies are evolving and how it's happening in other states, whether they're all sharing the same kinds of challenges.

State Medicaid leadership is very interested in learning from the peers in the business. That said, there is another reality and that is every state is very different. States' attitudes toward tax policies, states' attitudes toward health care spending, whether states are conservative or liberal, whether states have a tradition of large public programs or small public programs, those things can be very different and those also have heavy influence over the options that a state really has in going forward.

So there is more sharing. I think states would always say more sharing is better. There have been a few states in the New England area, for example, that have actually tried to collaborate in some purchasing around some of the infrastructure services, some of the processing, administrative

kinds of services but each state's procurement policies are different and established in law.

So again it can be sort of difficult to operate across those state lines. I think there is sort of a growing interest in where there might be the opportunity to take advantage of inter-state collaboration but it's pretty complicated.

DIANE ROWLAND, Sc.D.: I'll also add that in addition to the state administrators, there's a lot of interest in state legislators about learning from other states. We do some work with the National Conference of State Legislatures to bring together the key legislators at the state level on Medicaid and on some of their other health financing programs.

One of the challenges there increasingly, however, is that there's a lot of turnover because of term limits so that we're often doing more 101s with the state legislators than really being able to engage in some share practices but there clearly is a lot of interest in learning.

The other thing we watch very carefully is that travel is not a possibility for many at the state level. So that's one way that I think doing things like this kind of a webcast but also other web-related briefings that can disseminate some of these practices across states are important.

BARBARA COULTER EDWARDS, M.P.P.: The National Association of State Medicaid Directors is one of the sources that states look to to facilitate the communication across

states. In the area of HIT, in particular, it's a good example, the states that have received grants under the Deficit Reduction Act funding for a system change have formed a coalition, a collaborative, across those states so they can get together and learn from each other as they're developing information technology strategies for Medicaid.

So again I think the infrastructure to support that is important because there's not only turnover at the legislative level. There's often frequent turnover at the Medicaid director level as well. Folks are often on a new learning curve.

ANDREW BINDMAN, M.D.: I just want to add one brief other comment. My experience is that one of the things that's really challenging for a Medicaid agency is even when they're aware of some of these things or studies going on, both the time demands on real life decisions and some of the kinds of expertise that lives within Medicaid agencies isn't necessarily about evidence-based evaluation of research that's going on in different states about what's happening.

It was alluded to in my introduction that I'm part of an institute in California, which is a state university partnership with the Medicaid program. There are several of these developing in a handful of states around the country, Maine, Massachusetts, Maryland where the state university is working with the Medicaid program to try to help interpret lessons learned from research in the Medicaid programs.

I think that's another way that Medicaid programs can benefit internally from some of the resources they have within their states to try to learn how to evaluate evidence because it can be very hard if they're getting sort of bombarded with studies that seem to give answers that are 180 degrees opposite and to know whether did one do a better job, is one more valid, and so forth. So I think that's another piece of it.

DIANE ROWLAND, Sc.D.: Well Andy this questioner asks you to put on your research hat and elaborate a bit on the role of community health centers as primary care providers versus private physicians and to what extent are the community health centers really major contributors here or are we really looking mostly at an issue of private providers.

ANDREW BINDMAN, M.D.: Right. So there's no question that community health centers are a place that provide a disproportionate amount of care to people in the Medicaid program but in most parts of the country, it would not be possible for them to do this heavy lifting on their own.

So even though participation rates of the private practitioners can be relatively low on average given that is still the majority of what our delivery system looks like, they need to be a part of the puzzle at this point.

Having said that, I think there are ways that community health centers need to be bolstered and invested in so that they can be kind of the steam engine pulling along the whole

system and hoping to create a model of care that might be valuable for all providers involved to participate in.

Community health centers are also places that may take care of a disproportionate number of beneficiaries who are of limited English proficiency or other kinds of complex challenges that may be harder to attend to in the private setting.

So I think both are important. I think that if you go to different states and to different communities, you will find a different proportion or involvement of private practitioners versus community health centers but I don't want to give the impression that it could just be done by the clinics because private physicians, adding up as a whole, still play a very major role in providing services to Medicaid beneficiaries particularly as you get into more specialty care and the like.

ED HOWARD, J.D.: Andy let me just follow up to point out, and those of you who missed a round or two in the stimulus saga. If it plays out the way it seems to be playing out, there is a substantial amount of money for community health center infrastructure in that package.

The challenge is going to be what happens inside these newly refurbished infrastructure structures. If I can offer a commercial, we're going to be doing a briefing on that topic in a couple of weeks, February 23rd, you can mark your calendars and we'll pick up that conversation right here. Diane?

DIANE ROWLAND, Sc.D.: We've talked a lot today about Medicaid as a program that has a lot of variation across states and that there are mandatory benefits and optional benefits. This question pertains to what is actually an optional benefit under Medicaid prescription drugs but the question is do all states cover that? How does it vary from state to state?

Is it really a complete benefit or are patients still responsible for considerable out-of-pocket costs? How does it help connect them with complementary prescription drug savings programs in some of the states as well? So Barb?

BARBARA COULTER EDWARDS, M.P.P.: All states provide the optional outpatient pharmacy benefit. They do that because they view it as not only critical to good health care delivery that people have access to medications but also cost effective because while it's technically an optional service, if it's an outpatient service, if it's a mandatory service, if it's an in-patient service, and what you don't want to do is have people hospitalized to get some amoxicillin.

So every state has the Medicaid outpatient optional pharmacy benefit. When you check the box that says you're going to provide the pharmacy benefit, you have to provide it as the federal law and regulations describe it. This is one in which states basically have to take all or nothing.

There are states that might provide a more reduced pharmacy benefit if they could but they can't and that's partly

because there is a federal law that cut a, what I think is a very good deal for states, with the pharmaceutical manufacturers. That said, if the manufacturer participates in the federal rebate program that gives rebates directly to states based on drugs that are purchased in the retail marketplace for Medicaid on trade drugs that if manufacturer participates in the rebate program, the state Medicaid program has to include all of that manufacturer's drugs in the state's Medicaid program, okay.

So this is one where if you check that box on the state plan, you have to take a very large pharmacy benefit and make it part of your Medicaid program. Now states do have some ability to manage that program. They can manage it through how they set rates. They can manage it through how they use a prior authorization and in some cases may say well you need to, we're not going to prior authorize this drug if you haven't already tried this drug.

There's also the ability that states, almost every state now, is using that is that states go directly to those manufacturers and negotiate supplemental additional rebates in order to not prior authorize those drugs. So states have actually done a pretty good job of getting the price, the net cost of drugs down. They probably have some of the best pricing arrangements, net pricing arrangements in the country. I'm not sure anybody can touch it except maybe the VA, which actually

restricts where you can actually get the drug because it's distributed more narrowly.

So they do a very good job of managing the price. A lot of states are struggling more with the issue of managing utilization and again, managed care is one of the ways states have tried to get a better handle on the utilization of prescription drugs ironically because states cannot get access to the federal manufacturer rebates if the pharmacy benefit is provided through the managed care arrangement.

A lot of states are now starting to carve the drugs back out of the managed care arrangement in order to retain access to the federal rebate dollars, which is giving them a better net price but again they're giving up the advantage of better coordination of care when they do that. So there are some real challenges in managing the pharmacy program but it is a big program.

For those in the room who may not have been here when the Medicare drug benefit was passed prior to the enactment of that, Medicaid provided prescription drugs to the Medicare beneficiaries who were on the Medicaid program and now pays part of the cost of covering those individuals through Medicare through something called the Claw Back Provision. So if you hear about claw backs, claw backs have to do with the states continuing to have a maintenance of effort payment that helps subsidize the cost of the Medicare drug benefit.

ED HOWARD, J.D.: By the way, we're winding down in this Q&A time that we have left. Let me just ask you as you're listening to these last few questions and answers to pull out that blue evaluation form and fill it out before you leave. Diane?

DIANE ROWLAND, Sc.D.: Well I have a question to me here that asks if any models have been run in regard to seniors who find themselves Medicaid eligible due to reduced pensions or those who lost their retirement nest eggs due to the downturn in the markets. No, we haven't run any models like that.

Data tends to lag well behind economic trends, which is one of the problems but I think that you can see both on the insurance side as well as I'm sure on the aged and disability side, especially on the aged side that there are individuals who were previously just above the income eligibility levels for Medicaid that might now have fallen below depending on what they have experienced.

It is important, however, to note that while the asset test has pretty much been eliminated for children and many of their parents, there is still a very restrictive asset test in the Medicaid program for the aged and people with disabilities. That's about $3,000 for a couple, which means that very few people who were really having any kind of a substantial nest egg would at all be eligible for Medicaid even though they've lost most of what they had in their nest egg.

BARBARA COULTER EDWARDS, M.P.P.: It might speed up people becoming eligible for long-term care services under Medicaid because they would spend down faster the resources.

DIANE ROWLAND, Sc.D.: But it’s worth studying if we could. We also have a question for Barb because as she explained the financing, one of our questioners wants to know how it’s justified that states tax hospitals and nursing homes for revenue for Medicaid.

BARBARA COULTER EDWARDS, M.P.P.: Well it’s tax revenue. States can tax all sorts of folks to get revenue. I think that the question really mean, is asking and this has been sort of controversial in recent years, the idea that you’re taxing a health care provider who then is participating as a Medicaid provider. So you can actually raise their rates and basically given them back their tax dollar.

The question at the federal level has been is there really a state tax dollar in that payment or is it just some sort of a shell game. I would just point out that states that use provider taxes are using those provider taxes pursuant to the federal regulations that make it okay.

One of those requirements is that the tax has to be applied to all of the providers in that provider type. So for example, in nursing homes, you can’t only tax Medicaid providing nursing homes that accept Medicaid patients. You have

to tax even those nursing facilities that don’t accept Medicaid as a reimbursement.

If you’re taxing hospitals, you have to tax all hospitals in some sort of an equal way or some sort of a reasonable way even though hospitals participate very differently in the Medicaid program. Some hospitals are very heavily involved with providing services to the Medicaid population. Some hospitals actually do very little Medicaid business but they all have to pay the tax.

So the idea behind how you make this a legitimate source of payment in the federal regulations is that you have to apply the tax broadly and there can’t be this guarantee that every dime a hospital puts into the tax program is going to get paid back by Medicaid.

DIANE ROWLAND, Sc.D.: This question relates to the federal state relationship over Medicaid. It’s about what is the time period that a state plan amendment or a state plan is binding are states able to amend plans mid-year assuming HHS approves the plan and maybe more broadly, could you comment on how states and the federal government have been getting along over these issues.

BARBARA COULTER EDWARDS, M.P.P.: I want to know who asked this question. This is always asked. There is a lot of mother may I that goes on around state plan amendments. There are some time periods; I think they’re probably just federal

policy with regard to time periods that CMS will make a decision within, I don't know, 90 days of the state plan being filed but CMS is a master at stopping the clock.

Basically, it usually goes something like this. either they'll ask a lot of questions and say look we can either just say no or you state can agree to stop the clock and so you'll have time to answer the 15 pages of questions we just gave you at the last minute.

So there's a lot, some state plans can get approved within 90 days and some state plans may go for a couple of years and not get approved. I think there are some out there right now that have been open that long. So there really is no guarantee about how quickly they get approved.

States can file a state plan amendment at any time. So there's no sort of timeframe that you only get one shot at this a year. The state plans are enormously large documents, very complicated and states can be in there tinkering with different pieces of it on a fairly constant basis.

DIANE ROWLAND, Sc.D.: And the state plan amendment or the state plan stays in effect until the state opts to change it.

BARBARA COULTER EDWARDS, M.P.P.: Yes. Sometimes states have encouragement. Sometimes in recent years, the conversation has also gone like this. Well we won't approve the new one

you've asked for unless you've changed something else you already had approval for and we don't like anymore.

So again, it may be a state option to agree to have made that other change but states didn't feel much like it was an option, which probably goes toward answering the question how are the states and federal government been getting along.

It's certainly true that in recent years, there has been a great deal of friction, a lot of tension in part because CMS has been implementing policies that were designed to put what they thought was a very much needed increased, fiscal framework, fiscal accountability framework within the program and more consistency across states in terms of what states were allowed to do with Medicaid around some issues.

Some of that's probably been very needed and been good. There's also been a fairly significant amount, states would argue, of federal policy change that has also been attempted to be implemented through one-on-one negotiations around state plan amendments and that has caused a great deal of friction with states as well.

DIANE ROWLAND, Sc.D.: Okay. This question is with regard to the pressure on hospitals to provide a certain level of charity care and does that cost less effort by patients and providers to get enrolled in Medicaid because they could just go to a public hospital.

ANDREW BINDMAN, M.D.: If I understand the question, are you saying by coming to a public hospital, they're not-

DIANE ROWLAND, Sc.D.: It's the pressure on hospitals to provide a level of charity care and does this then retard the efforts to enroll people and get them insured?

ANDREW BINDMAN, M.D.: Well I can't speak to all hospitals, I will say at San Francisco General Hospital, the public hospital in San Francisco where I practice and I don't think this is atypical for a lot of public hospitals at least in California, we have many eligibility workers onsite who very aggressively pursue opportunities to try to enroll potentially eligible people for the Medicaid program.

In fact, if you look at the state hospital discharge data in many states, you will find that many people are recorded as being covered by Medicaid because hospitals make presumptions in many cases of the possible eligibility of someone for the Medicaid program even though later on, they may learn that for some particular reason, the person did not entirely qualify.

So in general, I would say in the marketplaces that I'm familiar with, hospitals are quite aggressive about pursuing opportunities to look to enroll people in the Medicaid program.

Now there are reasons that certain hospitals may be particularly aggressive and interested in that that we didn't emphasize so much today but there are programs called DSH,

Disproportionate Share of Hospitals that take care of greater portions of Medicaid patients and they will get reimbursed.

First of all, if their patient is on Medicaid on a sort of daily rate that they negotiate with their state Medicaid program but depending on the state and how the program is structured, typically if they exceed certain thresholds of having a certain number of their days paid for by Medicaid, they will be able to get additional dollars to support that hospital that are not tied to care of that individual patient but that are available for supporting the infrastructure of the institution in general as a hospital that provides a lot of charity care for Medicaid patients and those who are uninsured.

So it’s interesting that the questioner is raising whether there’s sort of a disincentive to do this given a hospital may want to have a certain amount of charity write-off anyway. I could imagine certain circumstances that hospitals might do that but again, in the marketplace that I see in San Francisco, there’s a very aggressive attempt and looking at our state hospital discharge data, to try to find people who are eligible for the program.

One of the probably biggest challenges around that for hospitals to try to sort through and different localities have different views about this has to do with some of the issues around immigrant populations and their eligibility and some of the sensitivities around some of the issues that are raised

about federal rules about who is eligible for Medicaid and different localities, San Francisco being an example that does not try to record and capture that information because it's a sanctuary city on that basis. So there may be some locality differences that come into play as well.

DIANE ROWLAND, Sc.D.: This question relates to the six Bush administration Medicaid regulations that have been subject to a moratoria and ask the speakers to comment on what the impact of these regulations would have been, what the impact of the moratoria is.

BARBARA COULTER EDWARDS, M.P.P.: Without going into a lot of detail on this, the tension that I was describing between the states and the federal administration was, for many years, one in which there really weren't any written guidance from CMS as to how they were making those decisions.

Toward the end of the administration, the Bush administration, CMS issued a large number of regulations, some of them proposed regulations that then went through public comment period and have to be filed. Some of them issued as interim final regulations, which meant after a comment period, they became effective to deal with a lot of these issues and to sort of say here's what we think ought to be the policy and the regulations.

States were enormously upset with many of those regulations. Providers, in many cases, were very upset with

some of those regulations. Advocates were upset with many of those regulations. There was a very interesting coming together of many different people around this broad range and this large volume of regulations that were issued. Some of them have to do with the rehabilitation option in Medicaid, targeted case management in Medicaid. Some of them had to do with how public hospitals and public providers could be paid and when an IGT or a CPE was valid, it was broad ranging in terms of the kinds of things that were dealt with with these regulations.

There was such an uproar over the regulations and in some cases, the method in which the regulations were being promulgated often with very limited public comment periods that states finally turned to Congress and said we just need these to be put in abeyance for a while.

Some of the regulations had been put into moratorium by Congress earlier and then as more regulations came out, states sort of banded together with providers and others and said could we just put a halt here and step back and take a look at these regulations and see whether they really make sense and which ones do and which ones don’t.

What’s happening is that these regulations were to, the moratorium was set to expire April 1st of 2009? Some of the regulations were actually in effect when the moratorium took effect. So if nothing happens on April 1st 2009, they go back into effect. Some of them were only proposed regulations, which

means the new administration would have to decide whether to finalize them or not. So again, you can't say the same thing about all six regs.

I believe that the stimulus package has extended the moratorium on all of them or some of them, some of them not all of them. Do you want me to read this? This is one of the things on the plane this morning I kept saying I'm not sure I have the right list on this issue. It extends the moratorium on Medicaid regulations for targeted case management, provider taxes, and school-based administration and transportation services through June 30, 2009, adds a moratorium on Medicaid regulation for hospital outpatient services through June 30, 2009.

Then there was sort of the sense of Congress that was described in this but the Secretary of HHS should not promulgate regulations concerning intergovernmental transfers, graduate medical education, and rehabilitation services at all. So as you can see, Congress has been pulled way into this discussion between the federal administrative agencies and the states. I would anticipate that some of this conversation is going to be ongoing even with a new administration.

ED HOWARD, J.D.: Diane, we have time for one more question.

DIANE ROWLAND, Sc.D.: Well I think that we should wrap up with the sense of our questioners about Medicaid being wrongly thought about as a program that people are looking for

a handout asking what the government can do to eliminate this misconception and another question saying but what are the most problematic components of Medicaid and how are they being reformed because I think the two go hand in hand.

BARBARA COULTER EDWARDS, M.P.P.: One of the challenges we have with Medicaid is we have a love/hate relationship with it. We turn to Medicaid over and over again to solve problems in other parts of the health care financing system, things that aren't covered by commercial insurance, things that aren't covered by Medicare. Let's let Medicaid take care of that.

Services, people who cannot afford coverage in the private marketplace, let's let Medicaid take care of that. People who have health problems that cause them to not be welcome in the commercial marketplace, let's let Medicaid take care of that. So we want and we need and we use Medicaid to support some really important public policy in this country.

In services like in the mental health world, Medicaid is the single largest payer of mental health services in this country and is providing over half of all funding that's public funding for mental health. So we have increasingly got a very broad network of the safety net and some very critical public programs that are dependent upon Medicaid as their primary source of financing.

I don't think it's about people that just have their hands out. I think it's about people who have very serious

health care problems who don’t find a viable alternative someplace else in our larger system.

At the same time, I think that’s probably the single largest challenge that we have is trying to figure out how to effectively manage services to the sickest folks in our health care system, in our country, the people that are most vulnerable, people that are going to need lifelong care.

How do you do that effectively and how do you finance that effectively because I think one of the challenges Medicaid and states deal with is that we are increasingly providing services to non-poverty populations particularly among the disability community and the aged through Medicaid because it’s the only thing there is but the financing structure for Medicaid sort of presumes it’s a poverty program.

I think that when you realize that’s 70-percent of the spending in the program, we really ought to go back and take a look and see do we have our arms around how you really manage a program for frail, vulnerable, chronically ill populations.

The other thing I always want to say when I’m inside the Belt Way is 40-percent of spending in Medicaid, 40-percent, is for people that are already fully insured through Medicare and yet, Medicare policy is established separate from the Medicaid program. The two programs are administered separately. There is no real collaboration and coordination between those programs for the beneficiary.

Forty-percent of the spending is for about 13-percent of the enrolled population in Medicaid and they're already fully insured by Medicare. We've got to come back and take a look at those parts of the programs and begin to make these systems of coverage more rational.

DIANE ROWLAND, Sc.D.: I guess I can put in a little ad here today. We just put up a new series of two policy briefs on our website, kff.org, on the dual eligible population and the financing challenges and some options for restructuring the financing between the federal government and the states. Andy?

ANDREW BINDMAN, M.D.: Yes, I'll just underscore some of the comments that were made. The challenges that we face in this country with regard to access to care that we're all familiar with related to the uninsured would be twice as large today were we not to have the Medicaid program. The Medicaid program goes an enormous way to providing access to the care to really the most vulnerable people in this country.

I can't say that maybe I've been duped and haven't realized that I've sometimes taken care of someone who was looking for a handout but it sure doesn't feel that way every day working in a public hospital clinic where patients work very hard to try to keep themselves healthy. They're suffering from a lot of different kinds of challenges in their lives.

I would say that I think one of the things that we really need to look at to reform is how to simplify the program

to allow it to work and not just be a band-aid at the most expensive, last-minute for patients but to make sure that it's there as a continuity coverage, a comprehensive coverage to allow people to really see this as a safety net program that can help them get back on the path toward health and to become as active as they can in our society whether that be working or engaging in other kinds of work.

So I think it's an incredibly critical program for access to care. It's not to say that there aren't things about it that could be better but I think we're very fortunate to at least have this as part of our safety net. I think there are opportunities through the kinds of things that we've talked about today to explore ways to make it an even more solid safety net for the most vulnerable in this country.

ED HOWARD, J.D.: That's great. Okay. Well thank you both. Those are, all three of you, some very insightful comments. Let me just ask one more time if you haven't done so already to please share your feedback with us on the evaluation forms and that goes for you folks who are watching the webcast as well.

If you go to the website either, I guess just on the allhealth.org website, there is a version of the evaluation form that you can either fill out online or print and fax to us. We'd appreciate it if you'd do that.

Let me thank the Kaiser Family Foundation and its commission for helping us put this event together and providing one of the stellar speakers. We thank you for sticking with us through a description of a complicated program that gets ever more complicated as we speak and ask you to join me in thanking our panelists for a lot of help in helping to understand this program [applause].

[END RECORDING]