



**Medicaid 101: What You Need to Know
Alliance for Health Reform
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ED HOWARD: -and on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors, I want to welcome you to this program on the basics of the Medicaid program. Medicare may be the largest federal health program in terms of dollars spent, but if you count the number of people enrolled in a given year, Medicaid is a lot bigger. More than 60 million Americans get Medicaid services in any given year and there is a lot of money involved, more than \$400 billion in combined federal and state spending in 2011. This is intended to be a basic education on this very complicated program and I suspect that we're not going to cover all the aspects of this program in even our very distinguished panel's presentations. I can infer something like that from the primer that our friends at the Kaiser Commission on Medicaid and the Uninsured have put together. The primer is 47 pages long. There will be a quiz on it at the end.

There are two big picture facts about this program that I want to emphasize as we get into this discussion. The first is that it's multifaceted. Medicaid covers kids and moms, it covers people with disabilities, it covers people needing long-term services and supports, it even fills in the gaps in the Medicare program for nine million beneficiaries. Second, it's about to get a lot bigger and more important as a result of

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some of the changes put in place by the Affordable Care Act. You can see why it's important to understand what Medicaid looks like now, what it does, who it serves, and how it's going to change; hence, our primer today.

Our partner and co-sponsor in this briefing, the Kaiser Commission on Medicaid and the Uninsured is a major initiative of the Kaiser Family Foundation. If you've done any research on Medicaid, you've probably used the analyses generated by the commission. You're going to hear from its Director, Barbara Lyons in a moment. I should note that early in the first session of each new Congress, in recent years the Alliance and Kaiser team up to hold a series of primers like this one on some of the larger health policy topics for those of you who are new to the issues or new to Congress, or have it as a new assignment in whatever your job is. We've jointly hosted a primer on Medicare a couple weeks ago. In the coming weeks we'll be one on the Affordable Care Act itself and another on health care costs in general. Thanks to the commission and to Kaiser, Drew Altman, Diane Rowland, and their colleagues for their active involvement in this important work and that is not a very subtle segue into turning to Barbara Lyons who's the Senior Vice-President at the foundation and Director of the commission who'll be co-moderating today's discussion.

Barbara?

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BARBARA LYONS: Thank you, Ed and welcome, everyone.

It's a pleasure to be here and to participate in this Alliance 101 briefing on the Medicaid program. As Ed said, Medicaid is big. It's an integral and dynamic part of our nation's healthcare system. Since its enactment along with Medicare back in 1965, the program has evolved considerably both as Congress has expanded the program on numerous occasions, most notably in 2010 with the ACA Medicaid expansion, but also as states have turned to Medicaid to, as Ed said, address the health and long-term care needs of their citizens. Today, Medicaid does provide vital assistance to millions of Americans, as Ed noted, from infants and children to seniors, and people with disabilities.

That said, millions of poor, uninsured mainly adults remain outside its reach. The ACA Medicaid expansion has the potential to address some of these gaps in coverage and we'll see what states decide to do and accomplish over the next year. State Medicaid programs are also very focused on once you have coverage what does that mean in terms of care delivery. With support from the federal government, states have been very focused on adopting new models of care delivery and innovations to improve the quality of the services that people actually receive and the efficiency with which those services are provided. I know we're going to talk a lot about that today.

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Ed gave a nice shout-out to our Medicaid primer authored by Julia Paradise on our staff. Despite its 47 pages, it's a good read and a tremendous resource so I encourage you to take a look at it. We do have quite a number of resources up here on the panel, so with that, let me turn it back to Ed and we will be able to dive in. Thank you.

ED HOWARD: Terrific. Thank you, Barbara. A little bit of housekeeping. You have materials in front of you. Those materials are also online at our website allhealth.org. By Monday, I'm not sure when on Monday, you'll be able to watch a webcast of this briefing. As a matter of fact, through the good auspices of our colleagues at the Kaiser Family Foundation, at their website kff.org, you can also get there through ours. In a few days, there'll be a transcript of the briefing available on our website. At the appropriate time, you can ask our panel a question. The green cards that you have in your packets will allow you to do that by writing it down. There are microphones that you can use to ask it orally and there's a blue evaluation form that we would plead with you to fill out before you leave to help us improve these programs as go.

One thing about the questions once we get to them, this is a primer. You should not be embarrassed about asking the most simplistic question because we know that you often are

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crammed with a number of assignments and maybe healthcare is only part of your portfolio. We want to get you started so no question too simple and, frankly, we have the experts up here at a level of sophistication that I'm safe to say no question too complicated that you won't get a really good answer.

DR. BILL HAZEL: Ed, Barbara and I are worried that you're setting us up because when we don't know the answers on what will happen, we'll be embarrassed.

ED HOWARD: Well that's part of what we're doing here, Bill. I think mutually among the four panelists you won't be able to stump the band but we'll see. We're going to start with Robin Rudowitz who's an Associate Director of Kaiser Commission on Medicaid and the Uninsured. She's been with the commission since 2004, held a variety of positions before that at CBO, the Lewin Group, CMS. We've asked Robin today to give sort of an opening lecture in the primer in the 101 course to outline the overall shape of the program and, of course, to do it within eight minutes, no problem. Robin?

ROBIN RUDOWITZ: I'm going to try to beat the clock. Thank you so much, Ed and Barbara. I'm excited to talk about this really important, complicated program especially now because it is such a historic time in the program's history. As Ed said, in a very short amount of time I'm going to cover the 47 page primer and really try to highlight five key points

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that I'll go over in terms of Medicaid. The roles it plays, how the money and spending is distributed, who's eligible for the program, how the program is financed, and then turn to the ACA.

So this first slide really echoes what Ed just said about the program. It really has multiple roles in the healthcare system. It's a program that provides coverage, it provides critical assistance to low income Medicare beneficiaries, it is the primary payer and provider of long-term care services in the country both institutional as well as community based. Medicaid represents one in six dollars spent in the healthcare system and it also provides really important matching funds for states to work with to provide coverage to their residents. That was the first key point.

The second key point looks at spending and how the money is really distributed across the program. I don't think I've ever really done a Medicaid presentation without this slide. It really just shows that the enrollees in the program are primarily made up of children and their parents, so about three-quarters of the enrollees are part of that group, but the spending is really concentrated with those who are elderly, blind, and disabled and that represents about two-thirds of the spending on the program. These individuals have much more

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complex healthcare needs and they use more acute and long-term care services.

Another cut on that point is looking at those who are dually eligible for both Medicare and Medicaid. We know that these individuals represent only about 15-percent of the enrollees on the Medicaid program but they make up about 40-percent of the cost of the program paying for services that Medicare doesn't typically cover, primarily long-term care.

The third key point I want to hit on is who's eligible for this program. I think there's a misconception that if you're poor you're eligible for coverage, but really prior to the Affordable Care Act Medicaid coverage was really for certain groups of people. There is really broad coverage through the Medicaid program for children and pregnant women and much more limited coverage for parents and adults. Right now, the median eligibility level for parents in the country is about 61-percent. Two-thirds of states cover parents at incomes lower than 100-percent of the federal poverty level. Again, prior to the Affordable Care Act there was no pathway for adults without dependent children to gain access to the program.

This is all really important because coverage matters and there's lots of research that shows that Medicaid provides access to care that's really comparable to private insurance

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and much better access to care and services than those who are uninsured. When you look at both adults and children, you see that those who have Medicaid coverage really have much better access to a usual source of care as well as access to getting the care that they need.

The fourth key point is really about financing. The Medicaid program is really financed jointly by the states and the federal government. There is a complicated formula based on the state's per capita income so poorer states have a higher federal contribution than those states that have high per capita income. When you look the total federal budget, Medicaid represents about seven or eight percent of total federal outlays, but when you look at state budgets it's a little bit more of a complicated picture and we see that Medicaid is really both a budget item as well as a revenue source for states. When you look at total state spending on the Medicaid program, it is fairly comparable to what states spend on their education programs. When you look at what states spend of their own, or their general fund dollars, you see that Medicaid is a far second to what states generally spend on education. Medicaid, it's important to understand, represents the largest source of federal revenues that are coming into the states so we often hear about Medicaid's role

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in state's budgets and it's not just an expenditure item, but it is also a revenue source.

Another key piece of the financing is that Medicaid is a countercyclical program. What that means is that during economic downturns you see higher unemployment, lower incomes, and that means more people are eligible for the program. Eligibility is the primary driver of Medicaid spending so if you look at this chart it really shows this point very clearly that during these economic downturns like in the beginning of the decade there's an increase in both enrollment and spending growth and then we saw that happen again during this last recession. We also see that as the economy has been slowly improving. In 2012, we saw pretty record low rates of growth in both enrollment and spending. We just put out a mid-year report of where states in 2013 and it looks like they're pretty on track for continued low spending and enrollment growth in 2013.

We also know that over the decade, as Barbara talked about, it's a dynamic program. States have really been working to control costs. Every year states are implementing multiple actions to look at ways to better control costs in the program. These have run across a number of ways provider payments looking at benefits and so there have been really a focus on these cost containment efforts over the last decade.

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There has also been a really important focus and this effort has really intensified in the last few years where states are really looking at implementing delivery system reforms and payment reforms as well as initiatives focused on these very expensive and high need population, the duals in particular. We are going to continue to watch what happens with some of these really important developments that states are working on.

The last key issue of course is the ACA. Medicaid is a key element of the ACA. It really provides the foundation of coverage for low-income individuals as part of the health reform law and this really shows that the Medicaid umbrella has really expanded to cover and expand coverage to those who have been typically excluded from the program and will expand largely coverage to adults on the program.

In addition to expanding coverage, the ACA really does a lot to simplify and streamline the enrollment process so there are provisions to encourage multiple ways to enroll in coverage: in person, on the phone, online, by mail, etc. There will be a single application for health coverage that covers multiple programs, much more increased use of electronic data matching, and, hopefully, moving towards real-time eligibility determinations. We know that nearly every state is really moving forward with advancing these new efforts. They are a

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requirement regardless of whether a state moves forward with the coverage expansion.

I love this new chart that we have because it boils down a very complicated report that we did down to one simple slide. It really looks at what the effects of the ACA Medicaid expansion and what we see is that the federal government really bears a large amount of the cost of the expansion. That's primarily because those who are newly eligible for coverage the federal government will pay 100-percent of the cost. It means a lot of increased coverage, so 21.3 million more people will be covered by the Medicare program if all states move forward with the expansion. That would mean along with all the other provisions in the ACA a reduction in the uninsured by about half. It also means some other savings for states including reductions, potentially in uncompensated care costs or shifting other money that states spend on other indigent programs as well as additional revenue for providers and increased economic activity.

I think in the end what really matters is what the ACA does for people. We just did a report based on a bunch of focus groups that show that obtaining Medicaid coverage really enables individuals to access care for the healthcare needs that they have, to access preventive care and it really improves not just their health but their whole interaction,

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their ability to work, their interactions with their family. I think relief is the main word that individuals had used to describe that coverage.

My time is beeping but I am on my last slide. I think looking forward into this year there are lots of things that we're going to be watching around the Affordable Care Act, how states are moving forward with coverage as well as eligibility simplification, the delivery system reforms that we talked about as well as what happens and continues to happen with state and federal fiscal issues. I did have "Will the Automatic Spending Cuts Go into Effect," and I think we can answer that today that, yes, it does look like they will go into effect.

ED HOWARD: Thanks very much, Robin. That sets the stage very well for the rest of the discussion. I should note that you can see on the bottom of the screen the hashtag if you want to join the Twitter universe and tell everybody about the fascinating conversation you're listening to. The next part of that conversation is from the federal side of that federal/state partnership that Robin was describing in the person of Barbara Coulter Edwards who directs the Disabled and Elderly Health program's group within the Center on Medicaid within CMS. In her previous visits to our dais, Barbara has been on the other side of the curtain, most prominently as

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Ohio's Medicaid director for seven or eight years. It's hard to name a lot of people who know more about Medicaid than she does and today, she's going to share with us a look at what CMS is working on with respect to this program including the preparations for the major changes that both Barbara and Robin alluded to as a result of the Affordable Care Act. Barbara, thanks for being with us.

BARBARA EDWARDS: Thank you very much. I'm happy to be here. As Bill was indicating, we're all a little nervous these days to say anybody knows everything about Medicaid anymore because it is changing pretty dramatically as a result of the Affordable Care Act and as a result of state action around this program as well. That's part of the excitement these days, so I'm happy to talk to you from a federal perspective at this point.

Medicaid is—the most important thing for you to know about it, it is a federal/state partnership. For those that are really comfortable in the Medicare world, that's sometimes the hardest thing to get your head around is that there are these states, and the district, and the territories and they all play a very key role in the program. There is a federal law, significant volume of federal regulations that create the frame for the Medicaid program. States within that have considerable flexibility to design the program they offer at

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the state level and they are responsible for administering the program at the state level and, as Robin pointed out, sharing in the financing of that program with the federal government. This is, in fact, both the strength of the Medicaid and sometimes the challenge is that is you've seen one Medicaid program, you've seen one program. It's really many programs serving many different roles at the state level and it really is I think what has been the strength of Medicaid and why it became a foundation for expansion for universal coverage in the Affordable Care Act.

Our goal these days is to be partnering with states, moving Medicaid from being a safety net program into a full partner in the larger healthcare delivery system, pursuing goals of better health, and better care, and lower costs so that we have a sustainable system nationally for all us whether in a public system or a private system.

Within Medicaid, we have two major areas of focus at the federal level these days and I want to just highlight those for you today. The first is, as Robin points out, the response to the Affordable Care Act and the role that Medicaid plays in the movement toward universal coverage in this country is that Medicaid is expanding. What is really exciting in addition to the number of people that will become eligible and be about to count on Medicaid to provide benefits are some of the changes

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that are talking place in the way eligibility works in Medicaid. The goals for Medicaid include simplification of that process, modernization of the experience of working, of being covered by the Medicaid program, getting that benefit package, and better coordination with the commercial marketplace. Medicaid is going to be moving in a place now where it's going to be much more closely aligned with what's going on the commercial market and particularly in light of the collaboration and coordination that needs to take place with state exchanges and the federal exchange on the private side.

There is a lot of change taking place as a result of this and in addition to the changes to eligibility, as Robin said, more reliance on electronic systems, online, telephone, a Zappo's experience if I'm allowed to say that, my favorite shoe store. We're really trying to find a more modern experience for people and that there will be a single front door into affordable health coverage whether it's in the private market or in the public marketplace, so that's important.

As we move forward on that we're also looking a new definition of a minimum benefit package at least for those who are newly eligible for the Medicaid program, those covered under the new adult eligibility group. That is the essential health benefit that has been defined under the Affordable Care Act and through regulation for both the commercial market for

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qualified health plans and for the benefits for those who are newly eligible for Medicaid. There is again this closer alignment in Medicaid with the commercial marketplace as well as our traditional responsibility for serving those who are particularly vulnerable and high cost in healthcare. All of that is in fact changing Medicaid I think toward the future in a way that we are still experiencing.

The goal is that Medicaid and the exchanges and the subsidies both through public insurance and in the exchanges will lead to a market in which people are fully covered either through Medicaid or is low income children through CHIP, the Children's Health Insurance Program, or through the exchange. This is, in fact, the goal that we are all pursuing in collaboration with the CCIIO folks in terms of the development of the federal and state exchanges.

The second major reform that Medicaid is pursuing at the federal level really has to do with its role as a player in the larger healthcare delivery system and that is the larger issue of health system reform itself toward better care, better health, and lower cost over time in the healthcare delivery system. Some of the major focuses in Medicaid at the federal level in cooperation with states—again, this is a federal/state partnership, which means nothing happens unless states in fact pick this up and implement these activities through their

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programs. The areas of focus that we are paying attention to at the federal level are payment reform, trying to provide additional opportunities for states at the state level to shape the way that healthcare delivery operates and the outcomes that are achieved through healthcare interactions, through capitation payments, shared savings opportunities, new kinds of integrated care models. Those have become important issues for states and we're working to try to make those more accessible in Medicaid.

Quality Measurement and Improvement: There's a lot of attention in the Affordable Care Act and through the CHIPRA legislation for adult core quality measures and children's healthcare core quality measures. There are additional activities being financed under the Affordable Care Act and embraced enthusiastically toward developing better measures of care and quality so that we can increasingly see systems move away from paying for transactions in healthcare and beginning to pay more for the outcomes that we're all seeking in terms of good healthcare.

Integrated, Person-Centered Care is a high priority for the Medicaid program. We are encouraging states in their interests in finding better integration both of primary acute and long-term care services around an individual's needs.

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Physical healthcare and behavioral healthcare integration is a high focus. Medicare and Medicaid being integrated as payers is an important of the program and always with the long-term services and supports that Medicaid provides an important focus on integration of individuals into the community, those particularly who are living with chronic and disabling conditions.

One of the major focuses that we have picked up in the last few years has been paying more attention to the role that Medicaid plays in behavioral healthcare, mental health and substance use disorders. It's an important issue in terms of the expansion, populations that will be coming into the Medicaid program, but also critical to the larger goals we have for good healthcare in this country. We are paying a lot of attention to benefit design, to improved access for children, as well as issues of how we can better finance the right kinds of services through the state programs.

Finally, but never last for us is continued transformation of our long-term care services and systems so that people can receive those services in the settings that they prefer, be fully integrated into the community if that's what they prefer and is appropriate for them. Medicaid has been a real leader on this. States have been real leaders on this and we continue to see a great deal of attention paid to

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this. The Affordable Care Act in fact gave us enormously important new tools at the state level through the balancing incentive program to support continued transformation through extension and enhancement of the Money Follows the Person grant program that allows states to fund activities and services to help people leave institutional settings and move back into the community. Through other services like health homes and other financing opportunities that encourage better integration of services at the community level that includes physical long-term care and behavioral healthcare services that wrap around the needs of the individual. There is a lot of activity at the state level. You'll probably hear about that some from the state leaders here, but it's a time of great change and great excitement and we have a lot of anticipation of the improvements that are coming.

I've got a couple of website references here for people that want more information on what's being made available for states, how states are leading in this effort to move Medicaid forward into a modern healthcare delivery system and I encourage you to check us out at Medicaid.gov. Thank you.

ED HOWARD: Great. Thank you very much, Barbara. As Barbara said, when you've seen one Medicaid program, you've seen one Medicaid program. We have two exemplary Medicaid programs to have you examine at some depth with the help of the

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people who oversee those programs, so from the other side of this partnership to current state officials. I'll introduce them both at the same time so not to disturb the flow. We'll hear first from Charles Milligan who's the Medicaid Director in Maryland and then from William Hazel who's the Secretary of Health and Human Resources in Virginia. Actually, Chuck's duties are broader than just Medicaid. His formal title and responsibilities are as Deputy Secretary for Healthcare Financing in the Maryland Department of Health. Dr. Hazel is an orthopedic surgeon on the side but his department spans not just Medicaid and CHIP but also behavioral health, social services, Aging and Disability in all about a third of the commonwealth's budget. We are going to hear first from Chuck Milligan. Thanks for being with us, Chuck.

CHARLES MILLIGAN: Thank you very much. I want to jump on a couple things before the slides and I'll do the slides really quickly. I just want to contextualize it a little bit differently in terms of big picture and picking up on some of what Ed and Robin said. Big picture there's about 60 million people on Medicaid right now, so one in five in the country plus or minus, one in five in the country. Roughly speaking, Medicaid and CHIP are covering about one in three kids in the country; roughly speaking, covering about one out of four deliveries; roughly speaking, picking up about two-thirds of

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the people in nursing homes, just some context. Depending on how many states pick up the Medicaid expansion we could go up to about one in four people in the country on Medicaid.

With respect to dual eligibles, those people on both Medicare and Medicaid, there's nine million or so in the country. Ed mentioned that figure. These are people who are the most expensive people to Medicaid because they often are using nursing homes and long-term care. Many of them are poor seniors, although there are a lot of people who are younger, under age 65 with disabilities, but they are the most expensive population to Medicaid. They are also the most expensive population to Medicare because these are people who, for a variety of reasons, are also on Medicaid based on poverty, or mental illness, or comorbidity and they use more hospital services and other services than Medicare.

Just to give you a couple of other data points about dual eligibles, Ed mentioned that Medicaid is the biggest program of the two nationally in terms of enrollment. Medicaid's bigger than Medicare. Medicaid is also more expensive than Medicare overall, not to the federal budget, but in total budget counting the state funds. For dual eligibles, Medicaid spends more than Medicare on those dual eligibles so these people use hospital a lot. They use physician services a lot. They use Part D drugs a lot. The amount that they use in

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Medicaid services like long-term care plus the fact that Medicaid is picking up all of their out of pocket in Medicare, like in Maryland we're spending about \$250.00 a month for dual eligibles just in their copayments and deductibles in Medicare and Part B premiums, so just some data points.

I want to go through the slides quickly. Maryland is a state that's doing the Medicaid expansion. I'm just going to highlight some of things that that entails, but, again, I'm going to just sort of tee this up and see if y'all want to play stump the band later.

In terms of the eligibility system, we're building the system that Barb referenced. This is a brand new eligibility system, brand new eligibility rules coming out of the ACA, modified adjusted gross income. We're going to be linking to the federal data hub that CCIIO is putting together that has data from the IRS, Homeland Security, Social Security and others. We've actually been actively testing our eligibility system at the state level with CCIIO's system. It requires a lot of work and we're working very hard at it. I'm coming from a meeting this morning to do it. It's not going to be just for those people who are part of the expansion population, but a lot of the current Medicaid eligibility groups like the family, and children, and poverty groups are going to go into this new

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set of rules, how income and all that is calculated, modified adjusted gross income.

We've got about 800,000 people in Maryland who are in our program today, but come 2014 their determinations will be made based on a new set of income rules. By the way, this is really good not just because it's seamless then with higher income premium tax credits and the exchange and all of that, but also because the rules in Maryland will be the same. MAGI has a national set of rules. We're going to be the same as Pennsylvania, Delaware, Virginia, D.C., all of our adjacent states so as people move back and forth they're going to be at the same level for MAGI and it's not going to be very state specific income and disregard stuff—a lot of work.

We're building an expanded work force to get people enrolled. This included navigators that are part of the ACA. It includes shoring up our local health departments where a lot of eligibility for pregnant women and some poverty children come in. It includes shoring up our local welfare offices, our field offices, because a lot of these families, let us not forget, are going to continue to qualify for SNAP, the Supplemental Nutrition Assistance Program, which is set roughly at about 133-percent of poverty. They're going to want to get all of the benefits to which they're entitled including SNAP,

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so we're working on all of the eligibility workforce capacity building.

We're working on building capacity in our delivery system, that is to say the healthcare provider side of things. We did raise our rates for primary care by about 25-percent January 1st. A lot of this was in the ACA in terms of raising rates for primary care providers for two years with enhanced federal funding. Maryland chose to raise these rates for specialists too who do primary care visits, so all of what people refer to as evaluation or management codes these are really when you see a primary care visit or checkup kind of stuff. We raised those rates and we're actually now going to be paying higher than our biggest commercial insurance company in Maryland, our version of Blue Cross Blue Shield which is known as CareFirst. We're doing other delivery system reforms about all payer patients that are medical homes and other kinds of things to build out workforce in our delivery system to anticipate all of these new people who have a insurance card and expect to be seen.

Part of building delivery system capacity means working with a lot of sort of safety net providers and we've organized it into two groups of providers. There are a whole bunch of providers out there that really don't have a lot of experience submitting claims to insurance companies including Medicaid,

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but they've got grants. That is to say they get state or local pots of money, sometimes from HRSA federally, but sometimes from state and local sources and they don't know how to submit claims. It's never been part of their mission. It might be school-based health centers, it might be free clinics, it might be some addiction treatment providers, it might be others. As more of their population gets insurance and the number of uninsured people goes down, the need to keep giving grants goes down. We shouldn't be funding as if it's still a huge, uninsured population going into these free clinics if those people have insurance cards. Part of what we're doing at a readiness level is teaching these providers how to submit claims, how to get contracts, how to get credentialed, quality measures, HEDIS scores, all that kind of stuff.

Then we've got another group of providers that know how to submit claims. They're a part of the insurance world but they really focus primarily on Medicaid. They work in our world, but they really don't work in the commercial world so if they want to follow their patients who's moving back and forth as their income changes, they've got to figure out how to get contracts with Blue Cross Blue Shield, or Aetna, or United Health Care, or others. We are working with that group of providers like FQHCs and community health centers, and urban Indian providers, and providers like that that have really been

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very much a part of the public payer system, not so much part of the commercial system.

One area I want to highlight and picking up on Barb's point about behavioral health, we have a very robust public mental health system that serves a lot of people on Medicaid with severe and persistent mental illness, various serious addiction issues. Given parity and given the social health benefits in the exchanges, the commercial carriers really need to build out their networks for behavioral health and they do not have adequate networks to deliver essential health benefits to the extent of the ACA. They need those providers who have been playing in the public world, but those providers don't really have a clue how to deal with prior authorization, utilization review, and all of that stuff, so we're working on that.

We're adding new managed care organizations. We have a very robust capitated system. We're bringing on three new MCOs this year, including Kaiser Permanente, which is exciting to us because then Kaiser's going to bring all of their physicians who have not been part of Medicaid before. There's other MCO and insurance carrier activity as Medicaid MCOs want to get into the commercial world and vice versa so that they can follow their patients across programs and products.

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Finally, we're working on continuity of care. It's one thing for somebody's insurance card to be seamless like okay, I was Medicaid yesterday but now my income went up and I'm in the exchange today but if I have a disruption in my care that's a problem. There's pending legislation in Maryland's general assembly that would protect cognitive care in two areas. First, if I'm in the middle of a course of treatment with a prior authorization, like I'm halfway through physical therapy or a series of mental health visits, and then I change into a new program that that receiving insurance company will honor and allow me to complete that course, even if that provider is out of network so that I can finish what I started. Secondly, that if I got an authorization for example that I need surgery that that authorization will be honored and I'm not going to have to go back through a PCP and back through a specialists and say okay, yeah, the surgery's medically necessary. So that legislation is pending in Maryland, so we're working on those dimensions. I will stop there. I'll look forward to your questions.

ED HOWARD: Great. Thank you, Chuck. Let's turn to Bill Hazel.

DR. BILL HAZEL: Thank you, Ed. Our Medicaid Director is Cindy Jones and she's at a meeting today so she sent her secretary. I do not have the same subject matter expertise

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that some of my colleagues do here, but I will do my best. It's tempting to not use my slides and just do a little bit of response, but I'll try to do a little of both. I think Ed had originally asked me to be here representing a state that is not expanding and I'd like to take a poll of the audience. Who here read in the paper that Virginia's expanding Medicaid? Okay, raise your hands. I can't see. Who here read Virginia's not expanding Medicaid? Now you know what I'm trying to figure out.

What Chuck has told you fundamentally about the Medicaid program and what we are doing is identical in Virginia. I can tell you eligibility systems, workforce, provider capacity, and so forth, so don't need to go through that with you. What I do think is important is to reiterate that the states are different and separated as we are by the Chesapeake Bay and the Potomac Ocean (sic) we have a very different culture in Virginia. On the day that the sequester begins officially I must remind you there is no free money, that the taxpayers be they federal or state are the same people, which is one of the ironies. The most interesting piece is, is that state legislators do not like to raise taxes to pay for somebody else's promises. That's a challenge.

The second thing I'd like to say is that the real challenge we believe in Virginia is the cost of healthcare and

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we spend 18-percent of GDP. Everyone in this room has probably heard that—18-percent of GDP spent on healthcare in the United States. So what? As an orthopedic surgeon that's great. Bring it on. I mean 20, 25-percent is exactly what we need, more spent on healthcare, but let's put that in the reality of the global food chain. What country is second as percent of GDP spent on healthcare? Switzerland. I got ringers here. What percent is that? I'll help you—11 1/2 -percent. Now an orthopedic surgeon can take his shoes off and use his fingers and 18 minus 11 1/2 is 6 1/2-percent of GDP we spent in excess of Switzerland. Well Switzerland covers everybody. Any idea how big that number is? I'll tell you, staffers, the entire U.S. defense budget is only 3 1/2-percent of GDP. Twice the U.S. defense budget in excess of GDP is spent on healthcare and we're not covering everybody.

We look at the challenge in Virginia to remain economically viable for our children and grandchildren as having to find the balance and figure out how we use this opportunity to reform and payment system. If we can't do this, this is unsustainable the day the sequester begins, just to point that out.

Virginia has 8 million people roughly and some of them are pretty rough. We have about 970,000 in the Medicaid program. If you ask our governor, every time he mentions

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Medicaid he can't help himself. He adds, "The fastest growing program in the state budget since its inception." It now is 21-percent of our budget. What legislators at the state level don't understand is it's not just federal requirements but we do some of this to ourselves. For instance, of the 98-percent increase in our Medicaid costs in the last 10 years fully 38-percent of those were options that we chose to do, waivers for individuals with ID and DD. Someone who's trying to be honest about it has to say yes, but you do have to realize it's not just across the river that's making you do these things. A challenge of reform in the state is not just getting the feds to do things differently, but getting your legislators to stand up to constituent groups and say, you know we have to do things differently. It's a real challenge.

We see and are concerned by the cost shifting in the Medicaid program. Many of you saw the map of the country last year that showed that some of the states with the highest levels of coverage also do the most cost shifting, and pay their providers the least. We believe that hospital cost shifting is probably 35 to 38-percent to the private sector. It's better than having people who are uninsured under EMTALA being seen by hospitals and 100-percent is cost shifting. We've taken the view that there is this cost shifting, that we need to do Medicaid reform and innovation, and then as we save,

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and our projections for Virginia at a 68-percent take-up rate for Medicaid, we would probably in the first five years save a half a billion dollars for the Virginia budget versus baseline. The problem is that's only savings. The net 10 year cost to us is \$137 million. Boy, that's great. It's only \$137 million for Virginia to expand Medicaid at the 68-percent take-up rate but that only happens if the legislature can keep their hands off of that half a billion dollars in the first five years and put it towards the expenses in the out years. We haven't seen much evidence of legislatures being able to do that. That may be just a Virginia phenomenon, but we do worry a little bit about that.

Now we have done all the things that good Medicaid agencies and governments are trying to do. We're trying to become more effective and efficient. I have to remind the governor that Dr. Jindal—anybody from Louisiana here? If you're from Louisiana, you've heard you're doing the greatest Medicaid reform that ever happened. Virginia did most of that 17 years ago. We can't get that savings again. We have been a managed care state for a long time. We were putting our foster kids in managed care, looking at waiver utilization rates, and you will hear in our state oh, 30-percent is fraud. The Attorney General says that he's going to recover millions of dollars every day and return it to the Medicaid program. If I

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had a dollar for the promises, I'd have actually more than was returned in fraud recoveries. We do have to look at getting away from the "pay and chase" to more data mining and not paying, so those are things that we have to look at.

Behavioral health is a huge issue for us. It's always playing Whack-a-Mole. We solve a problem in one area, providers go to another area, and our expenses go up. I will highlight the dual eligibles, the Medicaid/Medicare, a big, big issue. Barbara and CMS are working with us. Chuck has hit that. That's where the money is. Sutton's law: if you're going to try to find cost savings you've got to go to the dual eligible problems and the problems are the incentives aren't aligned. We believe in Virginia that to do some effective cost management and save both the state and the feds money we would probably end up spending \$50 million a year and the savings would largely accrue to Medicare. Hard to sell that to our legislators and so we are looking for the budget alignment and I think we'll get there. I think that's on our agenda this year. That is not a criticism of CMS. We are working well on solving that.

What the governor's looking for is the really maximum flexibility for states under a comprehensive waiver. We will likely try to put in an 1115 waiver application and then consolidate all of our various waivers in that structure.

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Fairly simple if it's just administrative, much more complicated if we start tinkering at the pieces that go in it. We are asking for a set of static parameters from the feds. We want to do innovation in the state. We don't believe what you can do in northern Virginia is the same as what you can do way out in Wise County which is west of Detroit. People don't realize Virginia's that big. We have these rural areas. We want to negotiate pilots for innovation but we'd like to have some parameters in place so when we go do it we don't have to come back and double check. We want to put the rules in place and basically say as long as you stay in these parameters you can try things on a pilot basis that are regional.

We're really looking at what we can do to the Title 19 underlying Medicaid statute regarding not so much cost sharing, because people who don't have money can't share costs, but can we look at networks, limited networks to high quality providers? Could we say, yes, maybe you do have to take a smoking cessation course, something along those lines that we are not able to do currently.

Number four, we are looking at setting up a metrics in an analytic unit in Medicaid. One of the challenges for states that have gone to managed care is that means we often are not as good at managing the care of even knowing what's happening as we were when we were doing Fee-For-Service. As states have

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trimmed administrative budgets, it's really hard to know what is happening in the black box of a plan so we're trying to figure out how to get that information back. Then we look at the stakeholder engagement long-term. If we're going to do reforms we've got to keep the stakeholders at the table. If we just expand Medicaid, everybody gets what they want, how do we keep them there contributing?

I won't go through the phases. That's not necessary at this point, but at some point, Ed, I'm over time, but I could talk to you a little bit about what our innovation priorities are. They're listed here.

ED HOWARD: Great. I'm sure we'll get a chance to get into that. As I mentioned, you know have a chance to ask the questions that our panelists didn't cover directly. You can either write it on a green card or go to the microphones that are situated on either side of the room. If you do that, we'd ask you to be as brief as you can in your question and to identify yourself. If you hold the green cards up someone will take it from you and bring it forward. Barbara, I've got a bunch of questions that either have come in, in advance or were highlighted by the presentation. Feel free to jump in. Let me start with one just as a matter of clarification. Several of the speakers have talked about the 100-percent match and, Robin, you had that wonderful slide in your presentation.

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Would you just explain the difference between what's going on now in the Medicaid program with respect to the federal financing versus the state financing compared to this new increment that begins in January?

ROBIN RUDOWITZ: That's a good question. We covered that very briefly. Right now there is what's called the FMAP or the Federal Matching Percentage that states it's Medicaid's matching program so states pay for services for eligible beneficiaries and they receive a match aback from the federal government. That match rate varies across the states in the country and the poorer states, or states with lower per capita incomes have a higher match rate that the federal government pays. The match rate runs from a floor of 50-percent so that means for every dollar that states spend they get at least one dollar back from the federal government to a high of just over 73-percent in Mississippi.

What happens under the ACA is that for those who are made newly eligible by the law the federal government will pay 100-percent of the costs of those who are newly eligible for the years 2014 through 2016 and then that share phases down to 90-percent by 2020 and then stays at 90-percent. It's a much higher match rate than what states get for their regular Medicaid program and that is why a lot of the costs or the vast

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majority of the costs of the expansion are really borne by the federal government.

ED HOWARD: Terrific. Dr. Hazel?

DR. BILL HAZEL: If I could, I'll give you some very specific examples. In Virginia, we currently pay 100-percent for people in prisons and jails. If those individuals and the PPACA, when they are not in that facility overnight, if we expanded Medicaid those people would be Medicaid eligible when they are not under the roof of the prison or the jail. In nine years we think that'll save us \$290 million because they become initially 100-percent federally funded and they work down to 90-percent. A lot of the mental health benefits that we pay for now with 100-percent state dollars, if our benefit package for Medicaid included these benefit that gets us another \$290 million. Indigent care fits in there, and so forth, so that's how it works on the front end.

The difficulties we have are that as it tapers down there are still increased costs for the expansion population that Virginia has. We are different say from anybody from Wisconsin here? Your governor's brilliant. He's not going to expand Medicaid at all. He's going to add 165,000 insured and he's going to transfer all the costs to the federal exchange. I mean he's brilliant. We can't do that in the same way in Virginia because we aren't already insuring. We don't get the

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same benefits. The point is in the out years we have to spend more and I think across the country most legislators are really wondering, particularly in light of what's happening in Congress, is the money really going to be there? For us one percent is \$40 million. It doesn't sound like much in Congress, but to a state budget it is enormous and so a couple percent change in the match rate over time destroys a state budget.

ED HOWARD: Can I just take this one step further? I keep hearing about people who are worried, state officials who are worried that while the expansion population is covered at 100-percent federal match, I guess it's not really a match if it's 100-percent. If there are people who are now eligible who, given all of the publicity around the expansion and the mandatory requirement that individuals have coverage, sign up for the coverage that they're eligible for now, you don't get 100-percent. How big a worry is this woodwork effect that they talk about?

CHARLES MILLIGAN: I'm going to answer that question. I want to flag a couple of other dimensions of this cost issue. Our estimate in Maryland is we've got about 70-percent take-up right now of people who are currently eligible for Medicaid but in the program, so about 30-percent of the people who could qualify today are not in the programs based on our sort of data

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mining with the census and other uninsured data. We have built a financial model that we've published and it's out there as a resource for anybody who's interested. The cost of the take-up going up, which we do anticipate because of the simplified eligibility, the real-time adjudication that Barb mentioned and some other things, just advertising and all of that, that the take-up rate's going to go up. That is a cost to the state. That, by the way, also means insurance for the poor. There are a couple of other costs that I just tend to think get oversimplified in this conversation. With all due respect to my friends in the federal government, the 100-percent match rate is true but there are costs that I think in Maryland it's still a great deal. We've got a lot of areas where we're going to save money because we're doing stuff with 100-percent state funding that we'll be able to get part as expansion.

I just want to put two on the table that I typically put on the table in these kinds of conversations that go beyond the woodwork effect. The first is administrative costs are not matched at 100-percent even if you're having to staff up to deal with a bigger program. If we're spending more with utilization contractors, more employees, all of that, admin costs are still matched at the regular rate so if our infrastructure's going to grow, our costs are going to grow.

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The second one that rarely gets mentioned is if in fact, we need to raise provider rates, to build out enough provider capacity to go in Maryland from one million on Medicaid to 1.2 million people on Medicaid and specialists, and surgeons, and all of those providers are going to be seeing more people in their offices. They're going to want Medicaid to be a fairer payer and to not sort of pay at a discount. Historically, when the CHIP program came up in '97 in a lot of states, when states saw big expansions in earlier eras of Medicaid there's pressure on provider rates because it's a greater percentage of the provider's mix in the office. If you're raising your rates for a physician you're not going to only raise them for those people serving the expansion. If you are raising your rate from \$45.00 a visit to \$48.00 a visit that's going to cut across your whole program and the regular match rate too.

Now in sum all of that's in our financial model. In sum, it is financially in Maryland's interest to do this even apart from the health policy and equity and good governance parts of it. I do think that when you hear it's 100-percent fairly matched, why would any state not do it, it oversimplifies the rest of the costs associated with this.

ED HOWARD: Dr. Hazel, you want to add to that?

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DR. BILL HAZEL: To build on what Chuck has just told you, this is really important. The administrative costs are not inconsequential. We have too done the modeling just like them. We are using a 68-percent take-up rate for Medicaid in our projections. When you read in the paper Virginia will spend \$137 million over baseline between now and 2022 if Medicaid's expanded, that's a 68-percent take-up rate and at current Medicaid rates. That also means if you saved every dime versus baseline in those early years when we're saving, those behavioral health things I just mentioned, the prisoner, all that has to be saved to get to that 137.

If we had 100-percent take-up that number moves over 900 million for Virginia. That's the difference there. If we paid hospital's costs instead of 62-percent of cost adds two more billion dollars so now we've gone really three billion. If we brought physicians to Medicare rates adds another billion, so it goes from being 137 million to four billion dollars depending on the assumptions that one makes. That would be a new state expenditure, and understand our budget annually is only 45 billion, less than that. That is like a 10-percent budget increase right there just on those assumptions. Those are things we operate with the best assumptions we can, but those are really problems for state budget folks to try to deal with.

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ED HOWARD: Yes?

MR. JOE CALDWELL: Hi. I'm Joe Caldwell with the National Council on Aging. We're really excited about some of the options that Barb mentioned for states to transform their long-term care systems to provide more services at home in the community instead of in institutions and nursing homes. I would really acknowledge Chuck and Maryland. They were one of the first states that took advantage of some of those new options. I guess my question is we are sort of surprised that more states haven't taken advantage of those options so my question is as states are thinking about bigger things like the Medicaid expansion how can we make sure that long-term care doesn't get forgotten about and is included in that bigger vision? For either Chuck or Bill from a state perspective.

DR. BILL HAZEL: From a state perspective in our budget language last week, long-term care is stage three. We need to figure out how to make long-term care a higher value. That would generally mean more community alternatives, better care coordination pushed out of the community, working with nursing homes to eliminate the bounce-backs, free admissions, things like that. The challenge that a Medicaid agency has like in Virginia, people think of it as being this huge program. It'll be \$8 billion in 2014. It's run by 350 people and a staff of contractors. When states have come through the budget cuts of

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the last few years it leaves us with very, very little bench strength internally. Frankly, a lot of the work that we've done in Virginia, very good work, and I think it's been done with the help of RWJ. I don't know if anybody's here from RWJ, but if you are thank you, thank you, thank you, because we depend on them to help us through the thinking processes, and the analytics, and so forth.

Going to a state legislature when you have a choice between adding—no state legislator wants added bureaucracy. They just don't want to do that and so when I've got five people and they can be working on a dual eligible project or a long-term care project they're going to work on the dual eligible project right now until we get that done. I just don't have the people for it.

ED HOWARD: Robin, you want to add to that?

ROBIN RUDOWITZ: Just one other thing. We do a budget survey with the states each year. We put it out in the fall and we try to take a look at it across a lot of different policy areas and there are more and more states at least thinking about that because we look at what they're going to do in the next fiscal year and what they're adopting in their state budgets. What we also have seen is a continued effort in moving long-term care delivery from institutions to community based settings so even without taking up some of the new

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options, states have really for a long time been making those moves and continue to do so even in light of a lot of other cost cutting measures. That's an activity that goes along with some of these delivery system changes that states have been continually moving forward with.

CHARLES MILLIGAN: I do want to comment. I'll be really quick. Thank you for the compliment about Maryland. There are some great options in the ACA and I want to thank those of you who helped kind of work on that legislation. The Balancing Incentive Payment program is one, the Community First Choice option is one, some of the important changes to Money Follows the Person, some of the important changes to some other parts of this in the new Health Home Section 2703 options.

To echo Bill's point, states have come through a really bad recession where states have had to balance budgets and a lot of states just have resource challenges right now given everything else and states are prioritizing and different states have to prioritize in different ways. I do want to give a shout out to Barb at the end of the table because she's been great and her staff has been great spearheading a lot of these efforts and it does help a lot that Barb comes from a state Medicaid director background and really knows how the rubber hits the road.

ED HOWARD: I think that's a cue.

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BARBARA EDWARDS: Thank you. I'll say thank you very much. I've known Chuck a long time, so yes, be nice. I want to say for people to know because I think you'll be interested. We have nine states that now have a balancing incentive program grant approved and that is where there's a wonderful opportunity to get enhanced federal matching dollars across all of their community based spending that they can then reinvest in transformation of those systems. We have four more states that have an active application under review and I think what I would say is that given the bandwidth issues that states have, and it's been very real, we're actually really thrilled at the level of response we're seeing from states.

We have 46 states with Money Follows the Person now so it's almost national in its breadth. What we are really trying to do is to help states figure out how to use these different programs and leverage them together. Connecticut was a good example of it using Money Follows the Person resources to be able to support their Balancing Incentive program planning. We're really committed to doing that to help states figure out how to take advantage of the resources that are there, and trust me, the amount of money that states are spending on long-term care, it is not going to get ignored.

MR. DEREK BRANDT: Hi. Derek Brandt with the American Academy of Neurology. I was happy to see, Charles, you pointed

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out the fact of providing increased E&M rates to specialists within Maryland. For us it's a big issue because in the ACA they actually outline who specifically could qualify for increased E&M rates at Medicaid rates. They specifically listed internal medicine, family medicine, geriatrics, pediatrics, and internal medicine so specialists were also qualified by CMS when they wrote the final rule.

For us it's a big issue because neurology does about 60-percent or more on average in their practice as E&M care but we're not able to qualify because we're boarded under a separate board of psychology and neurology. Going forward I'd be curious to get your thoughts on having specialists that are primarily cognitive focused like neurology, psychiatry, OB/GYNs that aren't doing a lot of procedures into provisions that this in the future.

DR. BILL HAZEL: For my physician friends coming from the board of AMA a couple things need to be understood and I think right now when Chuck talks about the workforce problem incenting more people to do workforce in Maryland probably is taking it from someplace else. We're not actually increasing capacity very quickly in healthcare. That's a problem. In Virginia, we believe at current levels we're challenged in primary care particularly in behavioral health. Neurology is one of them, those whole things. The idea that we can continue

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to perpetuate the current Fee-For-Service system is probably flawed and so asking for higher E&M, higher this under Fee-For-Service and pay for volume is probably not a realistic long-term solution. What we're looking at in innovation and the governor's given us some innovation money to work with the general assembly's trying to take it away, but that's another problem. What we're looking for is how do you create a medical home model around a chronic disease situation? If the primary problem is dementia or neurologic disease, why are the physicians not looking about coming to us with models of how we can extend our capacity and give us what we want? That isn't somebody in the office doing a consult when it's convenient for them, but 24/7 coverage, access to records, regular checkups, less imaging and things like that.

I think that my challenge for my profession which I've spoken out for very strongly over the years is that the game's over. The game's up and the old system isn't working so I guess I'm going to push back a little. I don't think asking us to fix E&M codes is solving anybody's problem today and I think we've got to get past that and the sooner Medicare gets rid of it and gets rid of that elasticity that takes us back into all payment levels just plain doesn't work. Nobody in primary care believes it. Orthopedists, which I am, my practice was 50-plus-percent E&M, okay. It didn't help me.

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CHARLES MILLIGAN: I agree with what Bill's saying. I mean we really need to change the model of payment to more of a bundled rates and performance based. In Maryland, we are working on a variety of all payer patients out of medical home models. There's a lot of other dimensions to this that are longer term issues about training programs, what does GME buy, people practicing at the scope of their license, how to use more care coordination and paraprofessionals. All of those are dimensions to this issue. How to use electronic health records, how to use telemedicine. This is a multifaceted problem and so I do concur with what Bill said.

MALE SPEAKER: Thank you.

ED HOWARD: Yes, go right ahead.

MS. SURI KINNEY: Yes, hi. My name is Suri Kinney. I'm an independent consultant. This question is for Chuck and Bill. We heard earlier Barbara mentioned that if you've seen one Medicaid program, you've seen one Medicaid program. Chuck, you said that the ACA actually is creating an environment where the rules are the same across the states, which if I understand you correctly could be a helpful thing that one day we will have a better system across the board. My question is, is there a mechanism in place today that would enable states to work together on common objectives? For example, as Bill said

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to set innovation priorities or to define an innovation pilot that would support multiple states.

ED HOWARD: You want to clarify what is uniform?

DR. BILL HAZEL: That uniform is pretty small.

CHARLES MILLIGAN: I'm being coached and it's good coaching by the way. For the eligibility part that's in the ACA a lot of the eligibility changes is standardizing for a large part of the Medicaid population the eligibility determination rules. What is not getting standardized is a lot of the other sort of dimensions of delivery system issues, how states are working with their local environments rural and urban, their local provider networks and delivery systems and other kinds of initiatives. What is not getting standardized is benefit packages across states. What's not getting standardized is a lot of other intervention states are doing in a variety of different ways.

There are mechanisms by which states are aligning and collaborating. There is various kinds of purchasing arrangements where states are working together. There are ways of sharing technology and sharing different innovative approaches. States are exploring that more and more, but it remains true that this—Maryland's the second state wherever on the Medicaid program. I ran the Medicaid program in New Mexico in the late '90s—completely different state, completely

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different demographics, geography, challenges of how rural it is, dealing with 22 tribal governments. The variation and viability at the state level is real so there are opportunities for collaboration. It tends to be more at kind of administrative and purchasing kinds of collaborations and less dealing with the variability of healthcare. At its core, healthcare is delivered locally still. I will stop there.

DR. BILL HAZEL: I would echo that. As I said earlier, what you can do in Fairfax is different than what you can do in Wise, Virginia or Hampton Roads, or any place else. If I can't make it uniform in a state like Virginia I don't think you can make it uniform in the U.S., particularly when we don't have a model that actually is that dramatically superior right now. What I think actually the advantage of the ACA or at least this Medicaid program has done, it's allowing more innovation in the states and perhaps in some ways variability. That is balanced by the fact that those of us who are sort of the worker bees in this thing talk regularly. You've got Matt Salo over here from the National Association of Medicaid Directors and they have meetings it seems like all the time and it's almost like there's too many meetings that we aren't getting work done. Not because just a few, but everybody wants to have a meeting to discuss X, so there's a lot of cross fertilization.

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I'd like to go back to that eligibility problem, Congressional staff. MAGI, people call it MAGI. We call it MAGI cause we're not sure it's wise yet. The problem is, is that Medicaid isn't the only program these people sign up for and an individual doesn't come to us to get health insurance. They come for help and sometimes they need SNAP benefits and sometimes they need TANF benefits, and sometimes they need WIC benefits, and sometimes these other things. The problem is, is none of those eligibility systems really are consistent and the standards are not consistent so fixing MAGI actually right now and particularly the simplified form is just giving our people more work to do, unfortunately.

LAVAR POINDEXTER: Lavar Poindexter with Men's Health Network. Is there any kind of an initiative to get new enrollees into Medicaid that might have underlying, unknown health concerns that they might not have had access to given that they haven't had health care in the past like walk in with Medicaid or something similar? Say someone goes to the emergency room is there any way to get them a screening before they enroll in the program to identify something to kind of keep from some of the costs from piling up later down the line after not identifying those problems?

ED HOWARD: Are you talking about eligibility screening or medical screening?

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LAVAR POINDEXTER: Medical screening in terms of making sure that we don't let things go by without seeing what problems people have before enrolling into the program.

CHARLES MILLIGAN: I will describe what happens in Maryland and not sort of adhering to the one program rule. What happens when somebody signs up is we have a vendor that we refer to as an enrollment broker. For those people who are enrolled in a managed care organization it's the vast majority of Medicaid populations in Maryland. Our managed care program excludes dual eligibles, excludes people with long-term care needs but for virtually everybody else statewide it's managed care. What happens is the enrollment broker conducts what we refer to as a health risk assessment. They ask about medication somebody's on, they ask about chronic illness, they ask about whether a woman's pregnant. They do a screen and that's health risk assessment and then ask the person to choose a managed care organization based on provider networks and they help counsel that person to choose an MCO. About 75-percent of our eligibles choose affirmatively and about 25-percent we end up then kind of auto enrolling.

For that group who go through that health risk assessment the MCO who's receiving their new member gets with that this health risk assessment and their case managers are expected to contact that person within 10 days to start making

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that transition happen, so it is part of that. If part of your question was getting at just kind of how you set payment rates based on acuity and risk adjustment, that's part of what we're doing as well.

DR. BILL HAZEL: I mentioned earlier that Title 19 does limit what you can require people to do who are in Medicaid. Some of it's around cost shifting, some of it's around localization of programs not statewide, and etcetera. What we are looking at and I'd encourage you, we won't do it now, to look at the concepts of value based insurance design and how you tie that to perhaps either requiring individuals as a condition of participation to actually have to do something for themselves. We've spent a lot of time and healthcare looking at the supply side, how we control the providers and how we do this and how we do that. At the end of the day, demand is part of the equation and we really do have to look more at the beneficiaries and asking them on behalf of the taxpayers who are supporting them to actually do some things that make sense. It may not be money. It may be limiting a network to a network you know that's going to deliver the goods better so those are things we'd like to be able to toy with.

ED HOWARD: Let me go to the next questioner but I should tell you that Barbara Lyons is sitting on about 127 green cards so if you're absolutely committed to getting your

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question asked you might want to jump to the top of the line by going to the microphone as this person has already done.

FAY GORDON: My name is Fay Gordon. I'm with the National Senior Citizens Law Center and thank you for this panel. My question, Dr. Hazel, you mentioned that one of the challenges with managed in your state is that you can't really tell what's happening on the ground sometime with the managed care organizations it's not as clear as in Fee-For-Service. I am wondering as Virginia moves forward with its eligible demonstration and states in general move to managed care for long-term services and supports is there a move for an ombud's office or some office that can sort of help report to the state what's happening on the ground so you can sort of alleviate this challenge of not knowing?

DR. BILL HAZEL: I think we do have an ombudsman office in Aging and Rehab Services so those things exist in a lot of places. I can't speak for other states but I know we have it. It's not so much that. Those are generally there for problems. What I'm talking about is actually getting raw data. How are people doing, how much of what is done, who's having complications. And individual who goes with a particular problem it may highlight, it may be a tip of the iceberg that we need to investigate further, but what I was addressing is

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the more general analytics necessary to know whether the services you're providing are adding value or not.

DEBBIE PLOTNIK: Thank you. Hi, I'm Debbie Plotnik with Mental Health America. Chuck mentioned that in Maryland they're looking to teach providers on the private side how to access insurance for behavioral health. My question is about behavioral health and the lack of it on the private side and how that affects Medicaid. In my experience, it keeps people poor so they can access services in Medicaid and I'm concerned as more people come in, again, this will be an incentive to keep people poor and what states may be doing to help grow the behavioral health access on the private side. Also, about prevention for young people in particular who may be already in Medicaid so they don't end up disabled or poor so they remain in the Medicaid system.

CHARLES MILLIGAN: Is there somebody in particular you're aiming that question at?

DEBBIE PLOTNIK: At anyone who wants to touch it. Is there anything going on at CMS? Is there anything going on in the states?

DR. BILL HAZEL: I can tell you what we're doing. We've got a fair amount going on and one of the issues we have, I mentioned earlier the innovation. I didn't get to that last slide, but one of our innovation work groups is around the

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integration of mental and physical health. I don't think number one, people who have mental health illnesses don't necessarily recognize them as mental health illnesses and the place they show up may be at a primary care physician or in medical treatment, or, frankly, in an orthopedic surgeon's office. I've seen plenty of it with something that is related due to pain management or whatever it is and we just don't, you know, when we're programmed in our cycles of, oh, I've got to take care of the tennis elbow, not the behavior that's driving the problem we don't deal with that. We're looking and trying to figure out can we do a better job of integrating mental and physical health, a little bit modeled after community care networks in North Carolina where they've hired psychiatrist to counsel the primary care physicians and to monitor how they're doing with the patients who have ICD nines related to mental illness. That is one of the things we're looking at to get capacity.

Another area where we're trying to build capacity, we have tremendous gaps in psychiatry, psychology, social workers in our rural areas. We have a fairly robust telehealth program and interestingly, that seems to work pretty well for mental health, so that is one aspect. Another area where that comes into play is around crisis intervention. We've been training law enforcement and CITs and what we're trying to do is when an

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individual is detained divert them into mental health treatment as opposed to giving them criminal records. It's easier today for law enforcement to put somebody in jail than it is to get them treatment so we are actively trying to address that by getting proper assessments. Telehealth in areas where you don't have resources is a part of that. We recognize limitations of resources and that does follow lack of funding, but one of the advantages of a Medicaid expansion is more funding for mental health.

MS. BARBARA EDWARDS: I'd just like to say we have a lot of activity going on around this area. With regard to your question on the private sector workforce I don't have a lot to suggest about that except to say that as providers in the public system become more comfortable with how to do billing and be a part of that system. Remember mental health and substance use services are going to be a part of the essential health benefits that are offered to the exchange as well as a service that's available in Medicaid. We think that is going to go a long way toward giving buying power to people and be able to stay employed and not have to stay poor in order to get these services. The issue of larger capacity is a shared problem that I think we all are thinking about and trying to find solutions to.

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Beyond that, we've been working very hard including with the American Academy of Pediatrics, the American Academy of Family Physicians, learning from them and the work that they've been doing in some of these areas about improved screening and how do you find better referrals and connections for primary care physicians who are encountering children in need. We are doing some work around trying to get better information into the hands of states so that as they are looking at improving their programs that they are aware of all the resources that are out there about screening and about models of care. We have a partnership with the Administration for Children, Youth, and Families with CMS and SAMSA looking at children in foster care in particular and better understanding the role of trauma that may be playing in the lives of those children and sometimes becomes a heavy behavioral health or mental health diagnosis when it might really be a traumatic related problem.

I think there's a lot of activity going on—we can talk more about it in other forums—around these issues and I think it's think it's one of the areas, both as a former Medicaid director and at the federal level. There's tremendous excitement and I think in growing recognition that it's one of the areas where there is the most room to improve. By improving we could perhaps make the most difference in terms of

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the cost of healthcare overall as well as the health of our community. I think we feel at the federal level that we have to play a more deliberate and attentive role around the issue of good behavioral health care and I think we're seeing a lot of interest and, in fact, a lot of leadership at the state level, particularly around the kids issue.

CHARLES MILLIGAN: I just want to sort of just rattle off a few things very quickly. First, Maryland and many states are building out their notion of what a patient center medical home is and what services ought to be included. We are certainly sort of integrating behavioral health in and also having many homes that are really where you are sort of putting the primary care into the behavioral house setting instead of the other way around.

Second, with respect to a lot of states that have health information exchanges, you know data hubs for sharing of electronic health records, we have one in Maryland. All 47 hospitals in the state are connected. When somebody hits the emergency room, while they're in the emergency room an alert is sent to that person's primary care provider if that primary care provider is connected. We've got now over 500 primary care providers connected to that system across payers so they get an alert, you're patient's at the hospital. We are folding in psychiatrists and other treating providers so that they get

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those alerts that say your patient's here and may be in crisis. You need to follow-up.

Third, a lot of the readmission payment reforms that are going on in Medicare, Medicaid, and other payers, people are doing the data mining and what they're finding is that about half of all readmissions to hospitals have an underlying behavioral health problem. Sometimes it's compliance with taking medications and adherence. Sometimes it's behavioral health conditions and so hospitals that are getting penalized in terms of reimbursement for that readmission are now starting to work back out to the community providers and shore up their discharge planning on the initial discharge to do a better job with all of that.

The third—excuse me, the 17th thing I'll mention on my little list is we are concerned on the commercial side about what our mental health community refers to as phantom networks which is a commercial carrier will say here is all of our mental health providers but none of them are taking new patients by the way. Part of network adequacy is going to look into that and with respect to the continuity of care I mentioned in the slides, one of the things is if somebody's coming over from Medicaid and they're stable on a psychotropic for example to not make them go back through step therapy all

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over again. All of that's part of what we're working on as well.

ED HOWARD: Can I just ask part of what the questioner had in mind was what was going to happen when we get this new population signed up. Am I correct that there is expected to be a disproportionate occurrence of behavioral health problems in this new population because you're going to have all these homeless folks who couldn't sign up because there was no category before or other reasons? If so, what do you do about that?

DR. BILL HAZEL: The short answer's yes. Why I say it's going to be capacity building as much as anything. You have to have the benefit in the Medicaid plan and you have to be adequate payment, and then you have to build the capacity. Because even if you're paying for it, if there's no one there to deliver it and I can pay more than Chuck can and then people move from Maryland to Virginia and he's got the problem it hadn't really helped. I think it's going to be looking more at a team based approach to mental health a little bit, how we use people. The top of the license language is tricky because at the top of my license I can do thoracic surgery, but you probably don't want me to. I'm an orthopedic surgeon remember, but there is not a monopoly on ethics and caring necessarily in the licensed professions. It's about knowledge and how one

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works in the team so I think that's how we're going to have to address it at least early on, sort of deputize the folks who can help and be trained to help fill that role.

MS. BARBARA EDWARDS: We are seeing a lot of interest in telemedicine. We're seeing a lot of interest on states to develop sort of organized networks of where the rare professionals can be available by phone or by internet to primary care treating professionals. There is creativity that can be done here and we can do a better job with it. I would just like to underscore we actually think it's a terrific problem to have because it means we're finally getting coverage extended for some very important services.

DR. BILL HAZEL: If my commissioner was here he'd slap me, but I didn't mention peer support and peer networks. We were out visiting in San Diego in December around military and veteran's issues. The leading cause of death in the military is suicide and with the discharges that are coming out we'll see more. We have a high population of veterans in Virginia and we are concerned about that so we're looking at the setting up the 211 line, encourage to call and perhaps actually if a person identifies as having served then they get to another person who has served so you've got a peer contact network. It's not just we have some money in the budget for suicide prevention and other pieces, mental health first aid we will be

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addressing. The trick is, is once you've identified an issue who do you call and Ghostbusters doesn't help you with that, so we're trying to create that network.

ETHAN JORGENSEN: I'm Ethan Jorgensen. I'm with the National Association of Public Hospitals. You were talking before about maybe institution at capitation or some sort of system like that. In my field risk adjustment comes up quite a bit. It's a sensitive topic for our member hospitals for various reasons but I didn't know if you had heard of any systems being employed that started a risk adjustment system within capitation or there was just going to be general capitation right now.

MS. BARBARA EDWARDS: I'll say just generally that in fact it's pretty common that capitation payments to health plans from states are developed in ways that reflect the relative risks of the different individuals who are being insured through that mechanism. In fact, in many places the way the health plans in turn contract and do business with the providers in their systems is Fee-For-Service. That Fee-For-Service might be a DRG payment to a hospital, it might be a per diem, it might be a service fee. There are, of course, some sub-capitation arrangements within those plans but I don't think that's the predominant way in which folks do business. I think as folks are looking at accountable care organizations,

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at other kinds of models you're seeing more of an interest in this idea of not fully capitulating a provider network or an accountable care organization, at least having more of an episode of care or a larger responsibility so you're not buying transactions. You're trying to get toward that issue of buying the outcomes that folks want which include efficiency, quality, and good value. I don't know if Chuck or Dr. Hazel have specific state examples.

CHARLES MILLIGAN: I think that your point is well taken and sort of to tie back to the last question in Maryland we've actually expanded to some childless adults, the future ACA expansion population, we expanded early for a limited benefit so there's not inpatient benefit but we provide outpatient specialty, behavioral health, and primary care and some things. We've got about 80,000 people on our program right now who will roll into the full benefit expansion. These are childless adults below 116-percent of poverty in Maryland. Many of them have behavioral health issues, many of them have addiction and we're going to be using a risk adjustment strategy that involves the medications that they're prescribed as an indicator of their diagnoses. There are some pharmacy groupers that as a risk adjustment tool that say if you're on this set of medications you're likely at this kind of acuity and this complexity. It's not a perfect instrument, but it's

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an instrument we're going to be using to pay that expansion population because we have some data now.

With respect to your providers in your association, I think the ACO models and bundled payment models that involve hospitals do need to reflect the fact that public hospitals tend to see a sicker population. They tend to see a safety net population. There is a lot of segmentation in the hospital market and for-profit hospitals tend to skim and other things like that. To the extent you're taking downstream risks there has to be a good risk adjustment model and there are some tools out there for that.

ED HOWARD: Barbara has a number of questions. I would just ask you as we take these last few minutes to deal with some of those questions that you pull out the blue evaluation form and fill it out as you listen to the Q&A. Barbara?

BARBARA LYONS: Thanks, Ed. We have a couple of questions around coordination with the exchange and how the federal hub will work and will everything be up and ready to go in October, and what are the issues that folks see if anybody wants to comment on some of that.

DR. BILL HAZEL: I'd like to hear that answer from CMS.

ROBIN RUDOWITZ: If my colleagues from CCIIO were here they could do that.

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DR. BILL HAZEL: I can just say in Virginia we obviously are not building an exchange. The general assembly has decided that we can do plan management for the exchange and I think we'll be ready to do that. We are building the eligibility system as well. We rolled out a customer facing portal for our social services last year and we are well underway in replacing our eligibility and enrollment system. The current one is built on I think vintage 1991 technology and costs \$17 million a year just to maintain. We are upgrading that with 9010 money that CMS has provided. We believe that is all goes well and, frankly, it's going to involve getting some information we don't have. We are at the point where we're having to make assumptions about what we'll have to do because we haven't gotten complete guides. I expect Chuck's got a little bit of that too, and not being critical, it's a huge lift in a very, very short time period. If everything goes well we will be able to do the MAGI determinations for this. What we have asked and we have gotten some funding to do is from the exchange funds is to create a data layer so that we can transmit information electronically. If an individual should come to us they're not going to know whether they're Medicaid or exchange eligible and what we'd like to be able to do is just to have those things screened and sent electronically to the federal exchange so we become a point of

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access as well. We think it's better customer service so we're working to try to get that accomplished as well.

BARBARA LYONS: Is there a cutoff date for states to decide whether or not to expand?

ROBIN RUDOWITZ: No.

DR. BILL HAZEL: If you don't start on January 1st, the 100-percent federal funding begins January 1st and it's for three years. If you come in six months late, you lose six months of that and continue on.

CHARLES MILLIGAN: I think it is worth mentioning this has been an area where there's been a lot of sort of activity from the National Governor's Association asking whether they could expand part way and not all the way up to 70-percent of poverty or 100-percent of poverty. HHS has read the ACA legally to say it's all the way or not at all. I think that will be an area where there will be continued ongoing lobbying from the NGA. Maryland is going all the way with that, but that's sort of a secondary issue about kind of incrementally expanding.

BARBARA LYONS: Another question that has come up relates to is there any talk of switching FMAP from per capita income to something that more accurately reflects a state's total available resources to treat low income populations? That's an issue that comes up periodically.

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DR. BILL HAZEL: You'll have to ask a Washington person that. I haven't heard about it, but Virginia's a 50-percent match rate state so we would like to get more.

ROBIN RUDOWITZ: Therein lies the interesting dilemma of any of those conversations. How do you have everybody get more?

ED HOWARD: No fight like a formula fight.

BARBARA LYONS: I'm going to take one more question because we're getting really close to two o'clock here but we'll circle back to long-term care once. What do you mean when you talk about community based long-term care? Does that mean an assisted living facility? Does it mean living in the community with family members? What are the options there?

ROBIN RUDOWITZ: It could be any of those. In some ways, we take some direction from the Americans With Disabilities Act that says that individuals living with disabilities have a civil right to receive public services in the most integrated community setting. That it's in fact a violation of civil rights in this country to require someone to be institutionalized in order to receive services that are appropriate and can be delivered in a setting of their choice. When we think about home and community based setting states have been working for years to create a broader array of options for individuals who need long-term services and

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supports and where Medicaid is the principal third-party buyer of those services. Families and individuals provide a lot of those services unpaid as well. We are looking at the full array and obviously that starts with an individual's own home and it might also include choices people make and their own home be an assisted living setting. What we have been working on at the federal level and with states and dialogue and through some proposed regulations is beginning to define what the characteristics of a home and community based setting are and what it means to be home and community based. It's been a fascinating conversation worth a whole other panel, but I think what we are looking for is sort of what is the individual's experience and what's their level of autonomy and ability to control their own lives. That's really what we're all working to support for individuals. It also in many cases can cost less money.

ED HOWARD: Two very good observations with which we can close this discussion. Thanks to you for enduring not only the first day of the sequester and the vagaries of the temperature of this room, but also for asking some really good questions some of which we actually got to ask. I think the conversation really reflects the fact that maybe this was the toughest 101 we're going to do. Here you have Medicaid itself evolving into a much more prominent component in the healthcare

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coverage fabric in the United States and you've heard a lot of that woven into the answers that our panel, which was not stumped, was giving to the questions that you've asked. Thanks for the questions. Thanks for filling out the evaluation form. I'd ask you to join me in thanking our panel for what was a very enlightening discussion of a very complicated subject.

[Applause]

[END RECORDING]

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