Medicaid: A Primer on the Federal-State Partnership

Alliance for Health Reform
March 4, 2011

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

[START RECORDING]

ED HOWARD: Good afternoon. My name's Ed Howard. I'm with the Alliance for Health Reform and I want to welcome you on behalf of Senator Rockefeller and our Board of Directors to this program on the basics of Medicaid. Now you may know this, a lot of people don't, in terms of enrollment; Medicaid is the biggest health insurance program in America.

As of last June, the enrollment hit 50 million I believe for the first time, more than Medicare of course. Over the course of the year, it covers even more, 60-plus million. The other thing is that it's costly. Counting both the federal and state government chairs, its price tag was projected to exceed $400 billion in fiscal 2010.

Two other things you ought to know about Medicaid is first that it's enormously important to the millions of low-income Americans that it serves and secondly that it's incredibly complicated, which is one of the reasons why we wanted to put this program together and of course, it's not only complicated but it's complicated in different ways in different parts of the country.

So we're very pleased to have you at this program. So many states are grappling with budget woes, looking closely at their Medicaid program, which accounts for a large part of

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

their budgets. That's why this primer on Medicaid is even more important.

We're very pleased to be the partner and the co-sponsor of this briefing with the Kaiser Commission on Medicaid and the Uninsured, which is a major initiative of the Kaiser Family Foundation. We'll hear from the deputy director of the Commission, Barbara Lyons, in a moment.

I should note that the Commission's executive director, Diane Rowland is also the executive vice president of the Kaiser Foundation and chairs the new MACPAC, which you may have heard of the Medicaid and CHIP Payment and Access Commission, which is designed to do for those programs what MEDPAC does in the case of Medicare for Congress.

This is a first, by the way, in a series of primers that we'll be doing with our colleagues at the Kaiser Family Foundation. Next Friday, there's a session on Medicare. If you're new to the Hill or new to the issue, these primers are meant for you. The announcement for that one just went out this morning. So you should find it when you go back to your office.

One thing that I wanted to emphasize, there are a lot of policy issues centering on Medicaid right now and frankly we're not here primarily to argue those issues out. Rather we want to get you a basic understanding of how the program works

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

because the idea is it's a good thing to know what you want to change or not change for that matter before you start debating those changes. So thank you for coming and at this point, let me turn to our co-moderator for today, Barbara Lyons, the deputy director of the Kaiser Commission. Barbara?

BARBARA LYONS: Thank you Ed and thank you all for being here today. We're really pleased to be able to partner with the Alliance for Health Reform to conduct these 101s briefings on the major health programs. I'm particularly pleased that Medicaid is the first one up.

As Ed alluded to and that panelists today are going to share in much more detail, Medicaid does play a really important role in our health care system both nationally and in every stage throughout the country providing financing for hospitals, physicians, and other medical services for millions of low-income Americans and also importantly, home and community-based services and nursing home care for people with disabilities and seniors.

We often think of Medicaid in its health insurance role for families but the bulk of the program spending is really devoted to people with disabilities and the elderly who have much more intensive health and long-term care needs.

We did put, on the outside tables, some profiles of the people who are served by the program because we're going to

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

talk a lot today about roles and policies but I think it's important to remember that the ultimate goal of the program is to help people meet their needs. We've highlighted some of the different types of people served by the program, a mom with breast cancer, a child with a brain injury, an adult with disabilities who's trying to work and contribute to society. These are the people who the program is really all about and intended to serve.

The structure of our panel today really reflects the structure of the Medicaid program. Medicaid is a partnership between the federal and state governments with shared financing within a national framework. Each state does determine what their individual Medicaid program looks like, which is why we hear so often when you've seen one Medicaid program, you've seen one Medicaid program.

There is a lot of variation throughout the country. The Kaiser Commission on Medicaid and the Uninsured has put a great deal of effort over the past 20 years into trying to collect information and conduct analysis on the Medicaid program nationally and collecting information from the states on who the program covers, what kinds of benefits are covered, how care is provided, and also how care is financed, and the budget issues that states are facing.

I want to give a big shout out to Andy Allison on the panel and all the other Medicaid directors and state officials who have worked so cooperatively with us over the past several decades in trying to obtain this information, which really helps us get a better sense of the evolution of the program and the direction that it's headed toward.

We've included some of these materials in your packets but we have a great deal more on the Kaiser Family Foundation website and also available at statehealthfacts.org for specific state level information. If Ed let's me take two more minutes, I just want to highlight some of the three key trends that we've seen in the Medicaid program over the past decade.

The first is the way that states have been responding to the growing gaps in health insurance coverage for the low-income population, most notably expanding coverage for children through their Medicaid and CHIP programs. Medicaid's reach for adults remains very limited in most states today.

Medicaid plays an important role for the poor, the number of poor in this country's increased by 12 million over the past decade. So it should be no surprise that Medicaid enrollment is going up. In the face of the recession, enrollment has climbed as more people have lost jobs and income and qualified for coverage as their incomes have gone down.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Medicaid's role has really played an important role in stemming further increases in the uninsured. The additional federal assistance that the federal government provided to states, $103 billion over 33 months is coming to an end at the end of June.

The second trend that we've noticed is the move toward more coordinated delivery systems. States have been working very hard to improve the way care is delivered to the people who are served under the program looking to managed care but also to other strategies to increase access to primary care, medical homes, and case management for people with disabilities.

Then third, states have also placed increasing priority on increasing the availability of home and community-based services for people with disabilities trying to avoid costly institutional placements, a very important direction for the program.

So the health reform law builds on these trends, expanding Medicaid to more fully cover low-income people in 2014, trying to fill in some of the gaps in coverage that we have today for adults, and also providing a number of opportunities for states to take advantage of new ways to provide care more efficiently, more effectively for the population served by the program.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So we've got a great panel today to look at these issues and to get the basic nuts and bolts about the program. So let me turn it back to Ed. Thank you.

ED HOWARD: Great, thank you Barbara. A couple of quick logistical notes, there are a lot of good pieces of information in your kits as Barbara said. There's also a sheet in those kits that lists a bunch of more resources that you can find online. There'll be a web cast available through the Foundation's beneficence as of Monday.

There'll be a transcript on our website, allhealth.org, a few days after that, find all the materials that you see in your packets and on the additional sheet on both the Kaiser website and ours, biographical information about our speakers, much more extensive than we'll have time to give them credit for today as well, and without any further delay, let's get started.

As Barbara said, we have a terrific panel. The first terrific member of that terrific panel is Robin Rudowitz. She's the associate director of the Kaiser Commission, been with them for about seven years. I had forgotten how long we had had this relationship. She's been focusing on financing issues during that time.

She's worked on health and budget issues at every level of government including a stint at CMS and in the private

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

sector as well. So eminently qualified to give us the brief overview of the Medicaid program to get us started, Robin?

ROBIN RUDOWITZ: Thanks so much Ed and Barbara. Thanks everyone for coming. We all know that Medicaid has certainly been front and center in the news, in state governments, at the federal level in terms of its fiscal impact as well as its role in implementing health reform.

So in the next 10 minutes, I'm going to provide a real basic overview of the program to get back to the basics and as Ed said, it's a really complex program. So these slides are structured in a way that there are five key takeaway points with lots of supporting evidence and data to support those points.

The first, as Barbara mentioned, Medicaid is really integral in the overall health care system. The program has a whole variety of roles in the current health care system. We are most familiar with Medicaid as a coverage program. It really covers certain categories of low-income individuals, primarily children as well as some of their parents and about 15 million elderly and individuals with disabilities.

Medicaid provides assistance to Medicare beneficiaries and it is also the largest payer and provider of long-term care services both in institutions as well as in the community.

Medicaid represents one in six dollars spent in the overall health care system and it is an important source of revenue, again, on the long-term care side but as well as for safety net providers. Medicaid is also, we know, a major budget item for states. It's also an important revenue source for states and federal government pays a large share of the financing of the program.

We have some recent polling data, which shows that over half or 59-percent of Americans say that Medicaid is an important program for them or their family. When you look at those statistics for the elderly, for those in fair or poor health as well as for Blacks and Hispanics, they are more likely to say that Medicaid is an important program for them.

We know that Medicaid is integral in the health care system because it really does fill in the gaps in our health care system providing benefits not often covered by private insurance or commercial insurers. It really provides a set of comprehensive benefits that really reflect the needs of the population that it serves so really comprehensive benefits for children covered by the program as well as a range of health and support services for both elderly and individuals with disabilities.

Today, the Medicaid eligibility levels are much more limited for adults than for children. There's very broad based

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

coverage through Medicaid and CHIP for kids. About 250-percent of the poverty level is the median eligibility for children across the country.

The Medicaid and CHIP programs cover over half of all low-income children in the United States at about 30-percent of all children in the country. We know that the coverage is more limited for parents and prior to the passage of health reform, states were generally prohibited from covering adults without dependent children on their Medicaid programs without a waiver from the federal government.

This next slide really just depicts the variation across the states and the coverage levels for parents. We see in this slide that really in the majority of states, coverage for parents is below the federal poverty level and in 16 states, there's coverage below 50-percent of the federal poverty level.

This second key takeaway point is related to Medicaid spending and we certainly hear a lot about Medicaid spending but this key point is that Medicaid spending, what drives is? It's really enrollment growth and spending for high-need populations.

So we all know that during the recession, you see increases in the unemployment rate as well as declines in people's income and therefore increased demand for programs

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

like Medicaid. Because of the federal legislation related to providing stimulus funds to the states in order to get those funds, states were really prohibited from cutting eligibility. So eligibility was protected during this last recession.

Since the start of this recession in 2007, we've really seen more than seven million more people enroll in Medicaid program. Our latest data shows that as of June 2010, Medicaid enrollment exceeded 50 million people on a monthly basis, the largest number on record. We know that this enrollment growth is really what's putting pressure on Medicaid spending growth. So as enrollment grows that therefore increases spending.

However, when you take out enrollment as a key driver of Medicaid spending and you look at what Medicaid is spending on a per-person basis, you really see that Medicaid spending growth per enrollee has been slower than growth in the private health care market. So if you look at total Medicaid per capita growth over the last decade of 4.6-percent, that compares to national health expenditure growth of 5.9-percent over the same period and increases in monthly premiums for employer-sponsored coverage of 7.7-percent.

Again as Barbara said, we know that Medicaid spending is concentrated in the elderly and disabled. So they represent about two-thirds of spending on the program but they only represent a quarter of the enrollees. When you drill down a

little bit further, we know that individuals who are eligible for both Medicare and Medicaid account for only 15-percent of Medicaid enrollees but a staggering 40-percent of Medicaid spending.

So the third key takeaway point that I want to talk about is that Medicaid increases access to care using private providers but a recognition that Medicaid is still purchasing care in the private market.

So despite the fact that Medicaid enrollees are sicker and more disabled than individuals with private insurance, we see on this slide that nearly 40-percent of low-income, of poor individuals on the Medicaid program report fair or poor health and many have limited ability to work. We really see that access is comparable to the access that individuals receive in private insurance, and far superior to access for those who are uninsured. Those measures of access are good on Medicaid for both adults and for children.

We also know that most states have opted to deliver care in managed care settings. So for data for June in 2009, we know that over 70-percent of Medicaid enrollees were enrolled in some type of managed care plan either a fully capitated plan or some type of primary care case management, but states are really managing the care that most individuals are receiving on the program and ensuring access.

So the fourth key point here is that financing for Medicaid is shared by the federal government and the states. This is something that we've certainly talked about. This map shows how costs are shared. There is a formula in the law that sets the federal matching rate and that formula is based on the state's per capita income.

It ranges from a floor of 50-percent to about 76-percent. Of course, states are receiving a bit more than that now because of federal stimulus dollars but this system is set up so that poorer states receive additional or more financial help paying for the program than states with higher per capita income.

We certainly also hear a lot about Medicaid in state budgets. So these slide shows really when you look at Medicaid as its role or as its in-state budgets, it looks pretty comparable to what states spend on education in terms of total spending.

However, when you pull out the federal revenues that states are getting to support the program and you look at just what states are spending of their own dollars on the program, you see that states spend about one in $6 of their state general fund dollars on the Medicaid program, so a far second compared to education spending, which is over a third of state general fund spending.

We know that health care is one of the few sectors of the economy that continues to grow even with the recession. The report this morning, it showed that there were additional increases in health care employment and when states spend money on their health care or their Medicaid program, they're again drawing down these federal dollars that then result in flows through their state economies and in turn result in income revenues and jobs at the state level.

Then I'm going to end really with a little bit of the fifth key point here, it is about Medicaid and its role in health reform. So the Medicaid expansion in health reform is expected to contribute significantly to the reduction in the number of people without insurance and we also know from analysis that we've done that the federal government is expected to pick up the majority of those costs.

This last picture here, before we sum up, is really just a brief look at Medicaid. We talked a lot about Medicaid's roles today and really health reform again builds on many of those roles by expanding coverage but providing lots of additional federal financing for that coverage as well as adding new options in the long-term care arena to help better coordinate care for high-need populations.

So amazingly, sticking to my 10 minutes with 30 seconds left to sum up, I just want to recap some of the key points

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

that we talked about. One that Medicaid is really an integral piece of the overall health care system providing help to lots of low-income folks and stemming the increases in the uninsured in recessions and economic downturns.

Medicaid spending is not out of control but really driven by enrollment growth and spending for high-need populations. Medicaid increases access to care but again still is purchasing that care in the costly U.S. marketplace. Financing for the program is shared across the federal government and the states and Medicaid will play an important role moving forward in the implementation of health reform.

ED HOWARD: Thanks very much Robin. Let me just make sure that everybody knows and to express how pleased we are to have you, Cindy Mann, who's the HHS official responsible for both Medicaid and CHIP among other things within CMS. It's her second period of service at CMS actually having done a lot of heavy lifting implementing the SCHIP program back in '99 to 2001.

In between, she was the executive director of the Georgetown Policy Institute Center for Children and Families and today, she's going to tell us not only what Medicaid's doing but about preparations for its role in reformed health care system in the future. Cindy thanks for being with us.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

CINDY MANN: Thanks Ed and thanks to the Kaiser Commission on Medicaid and the Uninsured and the Kaiser Family Foundation for putting this together. People say it's a complicated program. I think it's pretty simple and straightforward but it probably helps to have a primer and to help people go through it.

I am going to talk about, as Ed said, both a little bit about getting ready for 2014 and about where we are right now in the Medicaid program because I think it is fair to say that both for the federal government and certainly for the states, we are flying the airplane while we're completely rejiggering the engine.

2014 may seem far away but I think to Andy and to me and to those of us working on the implementation, it is now. It is here and the kinds of things that we need to do to make 2014 a success needs to happen today, yesterday, and tomorrow. So it is very much part of our presence even though obviously there's lots else going on.

So let me start by just briefly talking about what we're doing in terms of implementing, we're doing a lot of work with states. It has been a new experience for us in the Medicaid business at the federal level and I venture to say for my colleagues at the state level, also true with them, that we've been branching out in terms of who we work with and who

we talk to about implementation because it is very important certainly at the federal level that we not just work with our state partners but work with insurance commissioners, governors, health policy people.

Because as you'll see, a real central part of the implementation roadmap for Medicaid going forward is to be part of a broader system. That, for us, means that Medicaid, CHIP, employer-sponsored coverage, and the exchange really need to operate as a system.

So our work together at the state level has involved an array of players, obviously first and foremost, our Medicaid and CHIP directors but an array of players. So also at the federal level, we've been working with our partners at Treasury and the IRS as well as the Center for Consumer Information and Insurance Oversight, fondly known as CCIIO.

Of course we've been having a lot of stakeholder meetings hearing what people think health reform means, how we can properly implement it and do the best we can as we go forward. We've been issuing regulations and guidance and you will see in the course of 2011 quite a bit more aimed at 2014 coming out this year.

We've issued lots of guidance since March 23, 2010 aimed mostly although not exclusively at some of the provisions in the Affordable Care Act that are effective this year and

even last year but we're increasingly moving our guidance towards 2014 and the spirit of 2014 is now.

So if you look at the sources of coverage for Americans, and this actually looks at coverage just for people under 65 in 2019, it tells an important story it seems to me. What you see is first of all that the largest group of Americans will get their coverage through employer-sponsored coverage.

So just as they do now, employer-sponsored coverage will remain the largest single source of coverage for people under 65 as health reform is fully implemented but the second largest source of coverage come 2019 will be Medicaid and CHIP. That's because we're already building off, as Barbara and Robin made clear, a pretty robust base of enrollment, a strong program that's been around for many years and we're expanding on it.

So the other part of the pie to point to is the exchange of 24 million people. So that is the biggest delta. It starts with zero now at least at the federal level. Some states have their own exchanges but from the federal perspective, there's no one on an exchange that we're now paying for directly.

So that goes from zero to 24 million people, so the biggest change, but as you see going forward it is Medicaid and

CHIP together and it's mostly Medicaid. It's just a very significant part of the fabric of coverage as we move forward.

So what that means going forward is really a very different paradigm in how we think about Medicaid and CHIP. First of all I think, and I think this has been happening in states around the country already particularly with respect to their kids' coverage is it's too big to be thinking of as oh yes, yes, yes, Medicaid, that safety net program.

I should think about that. We don't think about Medicare that way. Medicare is a major public program for people over 65 and for some people with disabilities. Many people over 65 have private health insurance coverage, have retiree health insurance coverage and Medicare's available to them but, I think we all understand that it is a major source of coverage for people over 65.

Similarly Medicaid is the major source of coverage and will be certainly without a lot of holes in the system that it now has the major source of coverage for people who are low-income and people who need long-term care services.

I think getting away from thinking about it at the end of the line of a list of other possibilities will get us to position Medicaid and CHIP in a way that will assure the kind of coverage, quality, and cost containment goals that I think we all want to see out of health reform.

Secondly is to get us where we're going in 2014 and beyond, it requires a vastly different set of rules in the Medicaid program much more simplified rules, we get to these numbers not just because somebody's turning on the switch and saying more people are eligible for Medicaid but because fundamentally ways in which the program operates will change and the concept will be that everybody who's eligible for Medicaid needs to be enrolled.

Then most importantly it seems to me in terms of the new paradigm, which is related to points one and two, is that we need to think of Medicaid as being part of a system and we need to implement it in that spirit.

So if I show you the next two slides, I'll skip over them pretty briefly but they are really to tell you why Medicaid grows in the next world and it's really pre-ordained by the story that Robin gave us, which is that we have a lot of holes in our Medicaid system. People think that poor people are covered in Medicaid. Not so and what you see here is it varies by your category.

If you are a parent, if you are a kid, if you are a non-parent, your chances of being covered by Medicaid vary considerably because our eligibility rules in the program vary by category but if you look at the next slide, what you see is that pretty much goes away and come 2014, all adults will be

covered at least to up to 133-percent of income and it'll be a simplified, modified adjusted gross income calculation, same that will be used in the exchange for the premium tax credit. Kids will be covered wherever they are at their state CHIP and Medicaid levels as of date of enactment. So that'll vary by state and as Robin pointed out, the average is 245.

So we are getting rid of those, I overstate that, we're not getting rid of the categories. We're setting a uniform floor across the country. If a state wants to cover people in Medicaid above that floor, they still have the use of those categories to do so. Many will, particularly for people with disabilities and people who need long-term care.

The other way in which you really need to think of the world as fundamentally different and it goes back to the three-legged stool is that really come 2014, you have a subsidy system now available for people who don't have affordable coverage through the employer system that goes from zero-percent to poverty to a 400-percent to poverty.

There's no longer going to be that cliff for the individual who becomes eligible for Medicaid, gets a new job, or gets a raise in their job and then they have no eligibility for affordable care if that employer doesn't provide it. So the system anticipates that we will have a continual way of providing affordable coverage for people and it is up to us to

make that system real for families so that really flows in that kind of seamless way.

The first step that we've taken really to begin on the implementation for 2014 has been related to building IT systems. While you probably haven't, it's not usually the first guidance that somebody looking at the Medicaid program will turn to is their IT version 1.0, it's a page-turner but it gives you along with a couple other things we issued at the same time end of October and November, it gives you a sense of this system that we're beginning to pull together with states that really takes us to a new world.

We are anticipating that there will be seamlessness in coordination between the exchange and Medicaid and CHIP and our systems will be developed to support that and we have put more federal dollars on the table to help ensure that that happens.

We can't think about 2014 without thinking about the issue of who pays for coverage overall, the coverage expansions in Medicaid, the cost is borne by the federal government 95-percent, isn't to say that that five-percent isn't a significant lift for states. Of course it is and especially feels that way now given the difficult circumstances states are, states find themselves in.

There are other parts of the law that, for some states, find themselves seeing that the law will save them additional

dollars because of other offsets in the law that we can go into but I'm feeling the pressure of the time constraints.

So let me turn to the current fiscal pressures. It really follows what Robin said but let me try and put it into three key points. Enrollment among families and children has grown sharply during the recession. That, I would argue, and I hope none of us would disagree is a good thing. Medicaid is intended to be countercyclical.

It is intended to, as poverty grows, as people lose jobs, as people lose their health insurance coverage, and are within the income eligibility bands of Medicaid, they are supposed to be able to enroll in the program and get coverage that way. So it had functioned as it's intended. The problem, of course, is that that countercyclical function runs counter to state finances, which is at the time of a recession, they are in the least suited position to be able to sustain that enrollment growth.

Hence, the Recovery Act came in and helped states with paying for that enrollment growth but the rub is of course that those recovery dollars will end in June, June 30th of this year and we are still with that enrollment growth. So we have enrollment growth. It's what was intended. It's what was anticipated. It is difficult for states to be able to handle

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

without additional federal dollars and that's the situation they will find themselves in July 1st.

However, what really drives Medicaid costs, that's been the change that's gone on for the last couple of years because of the recession but underlying, if you dissect the Medicaid program and look at what's driving costs, you see, though this graph isn't that easy for folks to see from the screen, you see that our spending in Medicaid is highly skewed. One-percent of beneficiaries account for 25-percent of the costs. Five-percent of beneficiaries account for 54-percent of the costs.

Conversely, the five-percent of the beneficiaries that spend the least, I'm sorry, the 50-percent of beneficiaries that spend the least, they only account for five-percent of the costs. So yes enrollment growth has gone up.

Enrollment growth is the delta that states are dealing with but fundamentally if we want to deal with today and most importantly in the future of sustainability of the Medicaid program, we need to look at the cost drivers and they are not surprisingly the same cost drivers that we see in the system as a whole.

We are committed to look at those cost drivers. This is our formulation at CMS. We are looking at trying to improve people's experience of care. We are trying to, with other

partners, improve population health and we strongly believe that in doing so, we can bring down per person costs.

So we have reached out to states. The secretary has reached out to governors in particular. We are open for business in terms of new ideas, old ideas, sharing ideas. We've started some state-specific teams we call MSTATs, Medicaid state technical assistance teams. We now have 17 states we're working very closely with, again to think about what's on their plate, how can we help them given their unique circumstances, and how do we focus on the cost drivers.

Just to give you a sense of the balance of why we're looking at these issues in Medicaid, a study not done by us, showed and it's not much different than actually in Medicare or in private insurance, about 16-percent of, this was looking at Medicaid beneficiaries who are disabled, 16-percent who were discharged from the hospital, found themselves back into the hospital within 30 days, pretty typical unfortunately of our health care system.

Fifty-percent of those Medicaid beneficiaries who found themselves back in the hospital within 30 days, these are disabled people not people who like it's a surprise they have a medical problem. They had no primary care connection between the discharge and the readmission.

There are things we can and must do to improve care, integrate care, make sure there's good handoffs at hospital discharge and so forth that the community system is there for folks. If we avoided one hospital readmission for one disabled Medicaid beneficiary, we are paying the cost that exceeds the cost of covering a parent on Medicaid for a year. We need to look at the cost drivers and then we will be able to move forward.

So I'll just close because we're losing time here just by we're trying to come up with ways to explain that Medicaid is changing. What I've been saying although I sometimes get criticized for this by the elder community is that it won't be your grandmother's Medicaid program come 2014 but your grandmother may well be enrolled in Medicaid and get her benefits from the Medicaid program because we are the primary payer for long-term care. So I'm really thrilled that you're all here to hear about Medicaid and to get this primer about and I urge you to stay tuned because it's going to be changing and you want to keep up with the times. So thank you.

ED HOWARD: Great. Thanks very much Cindy. We've been hearing about Andy Allison for the first couple of presentations. Now we'll hear from him. He is the executive director of the Kansas Health Policy Authority, which puts him in charge, among other things, of the state's Medicaid and CHIP

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

and state employee health plans and he also happens to be the president of the National Association of Medicaid Directors. So he knows the real world problems of his state in Medicaid, hears directly from his peers about their real world problems and also about the good stuff. So we're looking forward to hearing from him.

ANDREW ALLISON: Thank you very much Ed and Cindy and Robin, terrific introductions, Barbara, and I just have to give my own shout out to Cindy and I'll just point right to the information systems issue, which I think does help to bring Medicaid forward in time. It's a program that Kansas can take advantage of and really was the first step. So I applaud CMS's effort to put that high on the list. I'm going to have a little different presentation. I hope I can get through most of it. I'll probably skip some of this or just consider it reference material or fodder for questions.

Let me start with a working definition of Medicaid from the state's point of view. This is really a two-page issue. Medicaid's an optional source of matching funds for states wishing to purchase health care for selected populations. I don't think of it first as an insurance product because states define the way they purchase that health care in a lot of different ways.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

It’s hard to opt out. No state has done it yet. That may become an issue but no state has opted out – too much money involved. It’s run by states. This is an old slide, over half the program and just about every state, certainly on average, certainly in Kansas, used to be optional. It’s not true right now because of the requirement in the Affordable Care Act to maintain your program. I’m not sure what percentage to put on it right now. It’s obviously an issue that states are working with the administration to address.

Another definition, here’s more of a statement of purpose. It’s the use of state and federal matching funds to meet the state’s greatest health needs. Why do I say this? Because many states are considering or planning to use federal matching dollars in one form or another. It might be the administrative dollars to do things like promote health information exchange or to use payment reforms in Medicaid or potentially a state employee plan to drive change in the marketplace.

So when Cindy points out that change in Medicaid might either be dovetailed or even help lead change in your health care system that’s true and just imagine when Medicaid gets bigger and is a bigger piece of most providers’ payer mix and revenue that lever becomes a lot bigger and at least presents

that choice to states to drive health systems' improvement through Medicaid that is something to consider.

I'm not going to spend too much time on the Affordable Care Act because I want to get to the last section of the presentation but we did do estimates pretty early on of the potential impact of the Affordable Care Act on Kansas probably we'll change a few things today but I did at least want to share these with you, things important for states to do this and for Congress to understand the very different impact that health reform or any change you would make in Medicaid could have on different states because they start from radically different baselines and I mean both dollars and program impact.

So this just demonstrates to you that we did do an estimate. It was a comprehensive estimate not just for what would happen in Medicaid but what will happen in the small employer market and the large employer market. One small point is if you look at an estimate of the impact on health reform on a state, if it doesn't include the rest of these, I would suggest to you that it needs to because they're missing, in part, one of the points Cindy made is we're going to have 11,000, Kansas is a relatively small program, we'll have 11 or 12,000 people who are enrolled in their employer but Medicaid's helping to buy them in.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

If you don't look at employer coverage when you're estimating the cost of Medicaid, you're going to count all of those dollars against your Medicaid program and you're not going to pick up the employer contributions. So that's just one example of why you want to do a better job and be careful when you're looking at the state impact.

Here's the other. This is my answer to the question, at least last May, of the impact of health reform on Kansas. It's that number. There are nine of them. Why did I give you nine of them? It's actually choices. You can't answer the question with a single number unless you're going to predict the policy choices that states will make as they implement the bill, for example, will you maintain all of the, in many cases, state-only spending on safety net programs for the uninsured like health clinic spending?

Are you going to maintain that if all the people that go to your health clinic are eligible for Medicaid and are being paid fee-for-service at, by the way, 100-percent of their cost for those services? Are you going to double pay for the uninsured once everyone's enrolled, if you're successful in getting them enrolled? That's a choice that states will have to make. Some states might choose to just pay once.

So those are the columns that you see if you cut non-Medicaid spending on the safety net in half, if you eliminated it altogether, if you didn't cut it at all.

The other issue is what will it take to buy you in as a Medicaid program to the physician's office or to the dentist's office? Let me rephrase that. I'm not sure there is enough money to buy you into a dentist's office in the Medicaid program but let's stick with docs. How much would it take? Are you going to have to raise rates? That's a conversation unto itself. That's the role that you see. I just want to leave you with the concept it is not a simple answer and in fact, it's dependent on policy choices that states will make and obviously on implementation, decisions that the federal government is making.

Now for the real story, which is between now and then although this slide is over the next nine years. So if, and what I showed you before was the annual net cost of the bill in Medicaid, so anywhere from negative 40 to positive $40 million state general fund, point estimate right in the middle of that in 2020 after the match rate comes back down to 90-percent, 10-percent for the expansion.

Now what's happening to the baseline Medicaid program in that time? Huge growth. That's $320 million I tried to take inflation out of it. That just gets you a sense of the

little sliver that you can't hardly see at the top, the $4 million. That's the impact of the health reform bill.

The rest of it's what happens because of growth in the number of aged and disabled and per person costs. That just is hopefully dramatically reinforcing what Cindy just pointed out. There's a whole lot to do to implement the bill, again commending Cindy for the first steps that are taken. If your state's not racing, they're behind. I'll just put it that way.

So where are we today in Medicaid programs? I can't give you a single answer because there are 50 states and not every state is at the same point along this path in the picture I'm going to paint for you. You've seen a lot of pictures of the economy. This is the one I want to start with. It's the percentage of the U.S. population that is employed.

What you will see is that we have just lost essentially a full generation's worth of growth in labor market participation in this country versus the whole population, an entire generation's growth. We're going back 25 years or more. That's what's happened to our employment base.

It's relevant in Medicaid because you're looking at that numerator/denominator, you're looking at both the revenue source for states in employment, the denominator is the growth in spending because you're looking at population. You're looking at aging. The population's going to grow. Medicaid's

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

going to grow or its costs are. That is, to me, a clearer picture of the future of Medicaid if we don't address it.

The other, you've already heard it here, is Medicaid growing because of the recession? Not unless we've been in recession since the day Medicaid was created, no, no. You don't see one year since 1966, year I was born by the way, that Medicaid has shrunk as a percentage of this nation's annual income except the year that they transferred part of it to Medicare with Part D and the drug benefit, the only year that it shrunk. This is not about recessions.

This is our state. Not every state would look the same and you've heard this. This is the last five years of growth broken out by population and what you're seeing is first aged, pretty flat. Then you're seeing growth, this is total dollars in Medicaid spending on disabled population and then the children and families, the poverty level groups.

So it's that third group that really grows with health reform but where's the growth in Medicaid? At least in Kansas, dramatically so, it's in the aged and particular, it's not the aged, it's really the disabled. That's where the growth is. Now if you project that forward and you don't change your program, you get a picture that looks like this, the number that starts on the bottom, this total spending and we're only projecting 7.4-percent growth.

You’re looking at a structural deficit of enormous proportions at least in Kansas because revenue’s not there. Revenue just changed permanently down in its growth path. It’s no longer even on that scale. We’ve got a problem and it’s rapidly approaching.

One of the things that states and Cindy again has already pointed out, if you’re going to address Medicaid spending, you always start with the big numbers in a management challenge. So this is just a picture of where the big numbers are in Kansas program. I’ve shaded in dark shade the big issues.

It’s medical spending for kids and families, for the disabled at about equal levels and then you see home and community-based services and then nursing facilities. So if you’re going to address spending, you have to address those big buckets and most of the big buckets are really with the disabled and the aging.

One of the dynamics that you’re seeing at the state level is attempts to instead of organizing purchasing across populations by service type, organizing spending or the purchase of care across service types within a population, a health home. What if you had a health home for the disabled? Well look at how bifurcated the spending is. How do you get

the circle of purchasing around both medical care and the other components?

So hopefully I've given you, the rest is there just for your reference and for questions later. Hopefully, I've given you a sense of where Medicaid is at least in Kansas. Not every state's in the same revenue predicament. I would argue though with disabled being driven by enrollment and social security at the federal level in large part, I hope I've given you at least one representative view of where we might be headed.

ED HOWARD: Great, thanks very much Andy. Our final speaker is Ron Haskins. Ron co-directs the Center on Children and Families at the Brookings Institution. In an earlier life, he spent 14 years on the Republican staff at the House Ways and Means Committee. He was a Senior Advisor on welfare policy to President George W. Bush in 2002. When he was at Ways and Means Committee, he was the editor of the *Green Book* and if you haven't seen the *Green Book*, you've really missed out. It was the most useful publication on Capitol Hill for decades.

RON HASKINS: You don't want to drop it on your toe though.

ED HOWARD: Well thank you for editing it all those years and thank you for being with us. We've asked Ron to take a look at what some areas of potential concern about Medicaid

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

in the future might be and foolishly agreed to do that. So thanks very much.

RON HASKINS: Well thank you. It's good to be up here, hanging out at Brookings with a bunch of old White guys it's real nice to come up to the Hill and be with young people that look, walk straight, and are wide awake and everything. I would like to give you a little advice. If you look down there at Andy at the far end of the table, he looks like about a middle-aged guy that's in good health.

Actually he's only 24 years old [laughter]. He has gray hair. He doesn't walk straight. He gets about two or three hours sleep a night and the two main reasons, here's how he spends his day. First, he gets calls from Cindy and other federal officials asking him why this group of 1,000 has not been covered by the Kansas Medicaid program and then between those phone calls, he goes into the Governor's office and the Governor yells and screams at him because he's ruining the state budget. So my advice to you young people is do not grow up to be state Medicaid directors [laughter].

Alright, I'm not much of a Medicaid guy myself. I took my own advice but Medicaid impinges on issues that I'm extremely interested in particularly four things. So here is the first one. This is an old chart. I've been trying, for

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

three years, to get CBO to upgrade this chart and I think they're going to do it but it still makes the point.

I want to direct your attention especially to the growth of, here's what would've happened in 1999 if none of the laws had changed after 1984 in work supports. Now work support is a very big support. Any of you interested in low-income families, I think it's the number one story of domestic world policy for say the last 10 or 15 years.

That is because Congress has deliberately created a system where people who leave welfare and work even at low-wage jobs, those lousy hamburger flipping jobs that people talk about, will leave poverty and they'll be much better off than if they'd been on welfare. The reason is that the federal and state governments resubsidize them.

In fact, if in 1999 after the Welfare Reform Bill and a huge outburst of employment especially by low-income mothers, we would've spent only $5.8 billion supporting that group of families but because of all the changes in these various laws here [referring to chart in powerpoint] after 1984 in fact, CBO estimated we would spend $52 billion. That is revolution. That is the work support revolution and it's much bigger today.

We are providing much more support for low-income working families. A big part of that support and a growing part of the support is SCHIP and Medicaid as you can see here.

If in your mind, you can add the purple and this whatever color you call that, I guess it's a Redskin's color and compare it to that, that's how much it's expanded and it's expanded way more than that since then [Referring to chart in presentation].

So this is the first thing about Medicaid. Under the old system, say roughly before 1996 or so 1997, we used to have to worry about the incentive to work because there were a lot of disincentives. For one thing, if you did the right thing and left welfare and went to work, you lost your Medicaid coverage and so did your children.

So once that problem was repaired (and it was repaired primarily by Mr. Waxman and mostly under bipartisan legislation), there was a whole series of legislation that covered kids completely outside welfare. Never mind if their parents are on welfare, if they met the income criterion, the kids were covered as has been pointed out previously.

We didn't do as good a job with mothers but those Waxman reforms are very important. Then in 1997 again on a bipartisan basis, we passed the SCHIP law, which covered millions of kids and that's the second reason that we have these great coverages outside the welfare system and we dramatically increased incentive to work.

Now the third step is the Affordable Care Act when presumably not only the kids but the mothers will be covered

and so we'll have even more work incentive for mothers and even fewer excuses for low-income families not to work even at the jobs that pay low wages. So the first point I want to make to you is that Medicaid is really a vital part of our work support system.

Medicaid has had immense effect on the country as a whole. Do you realize that today, after the worst recession we've had since the Great Depression, never married mothers are still more likely to work than they were before welfare reform even after their employment has gone down for four of the last six years and that for kids in female-headed families, they're less likely to be poor than they were before welfare reform, even now after several years of increase in child poverty. So this is a very big deal. It's one of the most, in my view; one of the most important parts of Medicaid is its implication in the work support system.

The second thing is that Medicaid plays a vital role during recessions. We've talked about that a little bit already. I think two people have mentioned it. If you see here during the recession in 2001, we get this nice increase in Medicaid and after the recent recession, we get an even bigger increase in Medicaid.

So Medicaid is doing exactly what a good safety net program is supposed to do. When people lose their jobs, they

have lower income. They automatically qualify. They get the benefit because it's entitlement. So it is one of our most effective along with unemployment insurance and food stamps, it's our most effective safety net programs.

In fact, our safety net programs are so good, you never read this in the paper, you know that during this horrible recession that we've had, child poverty did not go up? It did not go up even though families had fewer earnings. It didn't go up because federal programs leaped in there to fill the gap. If Medicaid hadn't done that, that would be a real problem. We'd have a lot more kids and a lot more parents that did not have health and coverage.

They'd have to try to get in emergency rooms and Andy can tell you what it's like to try to cover care in emergency rooms, doesn't work very well. So again, Medicaid is an essential part of the American system of social policy because of its effectiveness during recessions.

Then something that very few people talk about is the impact on inequality. I'm an avid reader of *The New York Times* and *The Washington Post* and I'm going to make a rough guess that the ratio of stories that bemoan how horrible inequality is in the United States and how it's exploded in recent years as compared with oh wait the government did a lot to offset inequality, it's got to be at least 10 to one.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

You hardly ever read anything good about inequality in America and in *The New York Times* or *The Washington Post* and many other publications as well.

Well look at these numbers right here. Here's what happens to people in the bottom 20-percent, so roughly speaking these are families below $22-23,000 a year. Before government transfers, between 1997 and 2007, their income actually declined. So life in the state of nature, so to speak, before any government help got worst but once we had government transfers like food stamps and other programs, they actually are better off by 9.5-percent over this period. *The New York Times* and *The Washington Post* will tell you that their well being declined.

Now if we add the tax transfers especially during Income Tax Credit and the Child Tax Credit, which provide billions of dollars, the ITC's almost $50 billion now, targeted exclusively on low-income families then their income improved by 15-percent and then if we do something hardly anybody ever does, add the value of health insurance especially Medicaid, some Medicare in here but mostly Medicaid, they are better off 26.4-percent if you just counted dollars. So Medicaid and Medicare do the same thing.

These programs play a dramatic effect in improving our inequality picture in the United States. In fact, for the

elderly, for people over age 65 if you look at the bottom 20-percent, the value of the health care that they get from Medicare and Medicaid is about 165-percent of their income. It's even greater than their income.

So the government does a lot. Our health insurance programs are a crucial part of that to combat inequality and Medicaid, if anything, is at least as important as Medicare. So for these three reasons, Medicaid is truly an important program for someone who's interested in poverty and well being and opportunity in America.

So now let me conclude with the other side of the story. There was a great economist at the American Enterprise Institute right here in Washington, D.C. named Herb Stein and he had a profound idea, he said any trend that can't continue won't. That's what I want to talk about right now for about one minute, any trend that can't continue won't. It's our spending on health care. It cannot continue. It will not continue. The crunch is coming.

I've sat through a million presentations on the Hill and Cindy Mann's an old friend of mine, I love her to death and she's talking about cost containment, so far nothing works very well, they're marginal effects maybe. Keep it up, I'm glad you're doing it. The states are not going to be able to do it.

All the state Medicaid directors are going to die of heart attacks [laughter]. We just cannot keep this up. The choices are limited.

Look at this, I've got 100 slices, you want to see more. Eventually we spend something like half of our GDP on health care. It ain't going to happen especially because we're going to have to, at some point, raise taxes, do that or the Chinese are going to own the whole country. So it won't continue.

Andy, there's a block grant in your future. Congress is going to pass the buck to the states eventually. They might not do it this year or they might not do it next year but they're going to do it and what they're going to do is give a fixed amount of money to the states, none of this open-ended entitlement stuff and they're going to say you figure it out. We very nearly did that once in 1996 and even the governors were willing to do it if they got enough flexibility.

It did not happen then, I think in my view, fortunately but it's coming and when that happens, these wonderful coverages that you've heard about here and the great expansions and all the terrific things that happen to low-income people because they're covered by Medicaid, it's going to be a new story. I don't think anybody knows what the outcome will be but it's coming for sure. Thank you.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Okay, thank you very much Ron. Presumably you don't know everything about the Medicaid program or didn't when you came in. Now you know a lot more to the extent that you have other questions that have not yet been addressed or would like to clarify something that you heard, now's the chance for you to step forward and try to draw on our experts to get that clarified.

There are microphones on either side of the room. There are green question cards in your packets if you want to write a question and hold it up, someone will bring it forward and you should not shy away from asking the simplest question. This is, after all, a primer but you got people up here that could answer the most sophisticated questions as well. So it's wide open. We'd ask that you'd identify yourself and be as brief as you can in asking questions.

SARAH CLIFF: Hi, Sarah Cliff with Politico. Thank you for putting this on. A question mostly for Cindy and Andy, I was wondering if you could talk a little bit more about the MSTAT program, how it's going, are these states reaching out to you? Are you reaching out to them? Any of them run by Republican governors and what solutions you all are talking through on kind of these cost control issues?

CINDY MANN: First of all, I would say that we like to think that we're always working in partnership with states.

What we've done through the MSTAT initiative is to be very explicit, very hopefully very nimble, and very available to states.

So we have, at this point in our official MSTAT roster, we have 17 states that have asked us to sit down with them. We think it's the most effective way of working because as has been said many times, every state's unique. So it allows us to really hear directly from the state what they're grappling with, what their particular cost drivers are, and how we can be of assistance.

So it has ranged from sitting through, in New York, the deliberations that they've done on their Medicaid Reform Commission that people have probably read about to having very small one-on-one meetings in a state conference room. So as you might imagine, we've got a variety of kinds of requests that are before us, states looking to expand managed care to populations they haven't put into managed care before for services they haven't put into managed care before, for example, on long-term care. That's an initiative that we think makes a lot of sense to look at.

We're talking to people about trying to blend behavior health, mental health services and physical health services that integrated care need seems, it doesn't always happen in the worlds of mental health and physical health. So there's

quite a variety of different things that are coming before us and we think it'll continue and continue to grow. We've gotten new requests every week.

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

ANDREW ALLISON: I would just add that I think that CMS is doing the right thing. Cindy came and talked to the Medicaid directors as I think they were considering the next steps for states that were facing financial difficulty and given Ron's comment and certainly the indications we've heard from at least a few states around the country, if you're going to consider the larger scale change in Medicaid then more than likely you first have to run down the issue of what's possible within the current structure.

So one way to look at the MSTAT process is what is possible within Title 19 and Title 21 looking ahead to the Affordable Care Act, what is possible for states that are facing, at various rates, are approaching this structural deficit that we're pointing to in really a very large scale. So it's very early so we don't have returns yet from states. I'm sure Cindy doesn't either but it's the kind of effort that needs to take place.

ED HOWARD: We have a number of people lined up with questions and let me just take a second to ask those of you who are associated with Congressional offices, we were unable to

arrange because of the physical attributes of this room, for a live web cast to which we could have invited your colleagues in state and district offices to tune in.

And so when you do the web cast that's archived, we're going to reach out to those folks, let them know that they can take a look at this program's web cast and we'd like to be able even to let them ask questions, which we can perhaps get some of our panelists to answer after the fact if they're not answered or if they're not answerable by the mere mortals at the Alliance and maybe you could encourage them to participate.

We've got a series of these primers as Barbara was noting coming up including one next week on Medicare. So if you could, let them know that this might be something that's worth their spending time on. We'd very much appreciate it. Okay, Thank you. Yes, go ahead.

BRIAN BLAZE: Yes. My name is Brian Blaze from the Heritage Foundation. when I was trying to learn about Medicaid, I went to Amazon.com and typed in Medicaid and seven of the top 10 books that came back dealt with Medicaid estate planning, basically this technique where attorneys write books that advise clients on how to qualify for Medicaid by artificially impoverishing themselves, by taking advantage of spend down requirements.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

And I was in New York, actually talking to eligibility workers and one of them was exacerbated and she said occasionally we still get a poor person on Medicaid for long-term care services. I was wondering if you could comment on that and whether that's a serious way of tightening eligibility for the nursing home entitlement component of Medicaid as a way for states and the federal government to save a substantial amount of money. Thank you.

ED HOWARD: Robin, you want to take a first crack at that or not? Andrew?

ANDREW ALLISON: We know these attorneys, several of them are on the opposite side of the courtroom from Kansas at any given moment, and think of Medicaid eligibility rules in some sense as a tax code and the IRS can and Congressional tax committees can't ever stop looking for the next shelter and that's certainly true in our relationship with the community that needs very expensive long-term care. So it's a significant issue and a number of states are looking at options to address that.

The immediate constraint and question is whether those changes can or cannot be made given the Affordable Care Act's requirement that eligibility rules be maintained. Well if you stopped maintaining the tax code and didn't update it for the next shelter, you can imagine what would happen. It doesn't

take very long in some cases. So that's an area of interest for states.

ED HOWARD: Barbara?

BARBARA LYONS: I was just going to point out that the rules around qualifying for long-term care were changed recently in the 2005 DRA where the rules were tightened up and the look-back period for asset transfers was shortened. Some new rules around home equity were put into place. The other thing I would just mention is that we should be clear that when someone does qualify for nursing home care they are required to put their income if they have a social security check or whatever towards the cost of that care and then Medicaid fills in the difference. They're allowed to keep a small personal allowance but the bulk of their income does go towards the cost of that care.

ED HOWARD: Cindy?

CINDY MANN: Yes, I was just going to mention the DRA changes. So there are some, there'll always be loopholes. There'll always be lawyers one looking, not one of the ones looking for loopholes but looking for ways for people to qualify but the rules have been significantly tightened.

The other thing to think about is that in this country right now, there's no source of payment for long-term care costs. Private insurance is generally not there for people and

if you are in long-term care for any length of time even if you have modest income at the time you started, you're likely not to have much income or assets over time.

So we have a broader long-term care problem to address in this country and it is a very important problem to address for the Medicaid program but it's not just people doing loopholes. It's the fact that we don't have a good financing mechanism right now.

Medicaid, therefore, has become that financing mechanism by default. It's a very important issue. I mean we, in the Medicaid program and haven't really focused on this sufficiently in this today, four out of every $10 in the Medicaid program is spent on Medicare beneficiaries. Medicare essentially does not cover long-term care. Clearly we would understand that many people on Medicare will need long-term care.

Medicaid picks that up. It is a big source of cost for the Medicaid program. So some of the broader issues of long-term care, financing the broader issue of Medicaid's role for Medicare benefit gaps are very important if we're going to look at that structural deficit that Andy talks about.

CHRIS JACOBS: Chris Jacobs with the Republican Policy Committee. A couple of technical questions but bear with me.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

First I wanted to ask Cindy what's the status of the impending Medicaid regulation regarding provider reimbursement rates?

I stumbled across a Supreme Court filing from last December in the Maxwell-Jolly case where the Justice Department said that HHS was planning to release a proposed rule on Medicaid provider reimbursements next month with a final rule by the end of the year. I talked with some of my colleagues on the Hill who didn't know about this and I don't know whether Dr. Allison knows about this or not.

We've heard a lot in the past week or so, the President saying state flexibility but I think a lot of governors might be concerned if there's a rule making process, they could suddenly slap them with another unfunded mandate in terms of setting some kind of floor, threshold for Medicaid provider reimbursements. Obviously it's an issue that limits access but it's also really one of the only tools that states have at this point or to manage their Medicaid programs. So that's kind of my first question, what's the status of that?

My second question involves the definition of MAGI. There was a footnote in Rick Foster's testimony before the House Budget Committee a couple of weeks ago where he said that excluding social security benefits from the MAGI threshold, which he at least implied was the correct statutory interpretation would mean that the CMS actuary estimates of

Medicaid coverage were understated by five million or more beneficiaries.

It's my understanding that CBO also did not exclude social security benefits from the MAGI threshold. The number up there, the 21.1 billion from the Kaiser urban study does not exclude social security benefits from the MAGI threshold. If you did that, more early retirees, more beneficiaries would be enrolled in Medicaid as opposed to exchange subsidies and the unfunded mandate costs to the states would be appreciably higher.

So I don't know, is CMS planning to put out guidance on this, regulations at this point because this is not a rounding error, this is a five million or more population talking about unfunded mandates to the tens of billions of dollars in the out years budgetary, and I think states need some certainly what's going on and it may end up that this Kaiser survey on the 21 billion and some of the other state estimates have actually underestimated because of this very important definition on the MAGI threshold.

ED HOWARD: In the interest of recognizing that this is a primer [laughter].

CHRIS JACOBS: I said they were technical when I started.

ED HOWARD: Why don't you start by telling some of us, anyway, what MAGI stands for.

CHRIS JACOBS: It's the Modified Adjusted Gross Income and because it goes off the definition in the internal revenue code and apparently the internal revenue code definition excludes social security benefits, which means anybody who retires at age 62 and takes early social security, they may not have outside income.

If their only income is social security, they won't go into the exchange at least if this is the interpretation. They will go on to Medicaid. That's something that will impact the Medicaid program and frankly, some early retirees won't decide to retire. It may not impact job lock because some 62-year olds may not want to go on to Medicaid.

CINDY MANN: Because of access?

CHRIS JACOBS: Because of access.

CINDY MANN: Then maybe we should do access.

CHRIS JACOBS: That's my first question.

CINDY MANN: That's where I was going, yes. Let me start by the first, you're an avid reader.

CHRIS JACOBS: It's amazing what you find when you read the footnotes.

CINDY MANN: Well in terms of the regulatory, we also put out a list of what regulations we plan to issue each year

and these access regulations have also been on our list of what regulations we expect to issue during the year. So we publish that, every year, we update it periodically during the year. So we have committed to issue regulations on the provision of Medicaid law around access and Andy knows full well about them and we're working with a number of stakeholders to talk about the regulations. We've had a couple of governors actually ask us for regulations.

We have a situation now whereas states are changing their payment rates for providers. There's been fair amount of litigation. As you noted, there's a case in front of the Supreme Court and states find, and we would agree, that having those rules the subject of different court decisions at different times is not good and predictable and thoughtful way to run a program.

So we collectively agree, probably not every state would agree but having some transparency and across the board rules about how we look at access, how states should look at access, what the public process ought to be, what the data sources ought to be will help provide some consistency to how states can administer the program.

In terms of the MAGI, there's a lot of changes in MAGI. First of all, I should say that there's a big debate as to whether it's MAGI or it's MAGI or MAGI. So the IRS who thinks

it belongs to them and it has in the past really shudder at the thought of MAGI.

They think its MAGI. So we regard them as the experts in this. There's a lot of changes in the income definition that MAGI represents and there's an up and down in terms of how Medicaid is considered now. So there is an issue around social security benefits, and it would affect a small number of people since MAGI in Medicaid only affects people 65 and younger. The Medicaid rules do not change, we don't adopt the MAGI definitions for 65 and older.

So there's ups and downs. There's a lot of changes. That's why I spent a lot of time with my IRS and Treasury friends in the point of the Affordable Care Act it is to have one consistent definition across the exchange and Medicaid so that people don't bounce back and forth and get different answers depending upon what coverage source they apply for.

CHRIS JACOBS: It is five million people, at least that's what the Medicare actuary says.

CINDY MANN: You'd have to talk to the actuaries about estimate.

CHRIS JACOBS: But do you know when there's going to be any clarity from CMS on this in terms of putting out the regs?

CINDY MANN: As noted before in terms of our projection on regulations, promulgation, this year is when we're going to

be issuing regulations, us, the OCIIO, and the Treasury. We plan to issue regulations on MAGI and some of those definitions. They will be proposed regulations. There'll be plenty of opportunity for thought and comment before they go into any final rule.

BROOKE BELL: Hi, I'm Brooke Bell. In contrast to the last question, I'll probably ask you an openly simplified one but after PPACA and going forward, what is the future of the CHIP program? I know there's additional funding and additional eligibility requirements or more people to be eligible but going forward, what's, if you could kind of read the tea leaves for me?

CINDY MANN: Well I won't read the tea leaves necessarily but I'll at least tell you what's in the law and then others might want to read some tea leaves. So the Affordable Care Act maintains the CHIP program, continues it through 2019, September 30, 2019. The funding actually is extended under CHIPRA, the law that preceded the Affordable Care Act that renewed CHIP program had extended funding to CHIP through 2013.

The Affordable Care Act moves that to 2015 and if funding still exists for the program, obviously it's up to a future Congress, the Affordable Care Act also ups the match rate for states an additional 23-percentage points. So the

average match rate for states right now in CHIP is 70-percent meaning states pay .30-cents on the dollar States pay, .70-cents on the dollar, the feds pay .70-cents on the dollar under the Affordable Care Act change effective 2016.

It'll be .93-cents on the dollar on average paid by the feds but it depends on what Congress does in terms of extending the funding for the program after 2016. The law doesn't expand eligibility for CHIP though, I just want to make that clear. States can expand eligibility for CHIP if they choose to. What the law says is that the minimum that states have to continue covering where they were on March 23, 2010. So it doesn't increase the eligibility levels relative to wherever a state was on enactment.

ANDREW ALLISON: I'll just add a little bit to that probably again oversimplified and not necessarily a prediction but what Congress had to do or did, I suppose, in the Affordable Care Act is kick the question of CHIP down the road. They just punted because the fundamental question is whether those kids end up with their parents in the exchange and private insurance. There was a debate about that and it just simply wasn't resolved.

So in the meantime, the feds essentially bought states out of the program or very close to it at the high match rate if I can again oversimplify. So it is an unresolved question.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I wouldn’t predict the outcome. There is a practical dilemma for states who run up against their allotment though and run out of the sort of capped block grant that CHIP is now funded through.

We’re not sure exactly who or how we will turn kids away once we run out of sort of slots no matter who’s paying the bill. So I think there’s some issues going forward but maybe should or should not be resolved until after we’ve seen what the exchanges look like, if they happen and what private insurance coverage looks like. My best guess is that’s what the political bargain was here, just wait and see what it looks like and then decide what to do with CHIP.

CINDY MANN: Just going to that, one thing we hadn’t talked about is a lot of states are thinking about, I know Andy is and other states are thinking about how to bring the same plans that are doing business on the exchange to be doing business in CHIP and in Medicaid, maybe not completely but substantially in which case the fact that a parent might be in the exchange and a child might be in CHIP considering that we have smooth, seamless coordination at enrollment, which is the expectation and that’s the IT guidance and all to the extent that plans are participating across the board or there’s a choice of plans that are participating across the board then.

The difference ends up being hopefully behind the scenes, which pot of money is paying for the coverage.

LIZZY DESANTIS: Hi. My name is Lizzy DeSantis and I'm from Congressman Gus Bilirakis' office. I had a question specifically related to Medicaid fraud. From what I've been reading, that's one of the things that drives Medicaid costs up so much and I was wondering if there's anything in the Affordable Care Act specifically that works to counter that fraud and if you all have any suggestions how to counter the fraud. I know that in Florida, they recently established a federal funding demonstration to try to do that and what are your thoughts on that? Do you think that'll be effective?

CINDY MANN: There's an error rate in the Medicaid program, which is different than fraud rate. The last national error rate was about 9.5. It's erroneous payments. Sometimes it's fraud. Sometimes it's lack of documentation from the provider or from the beneficiary. It's a relatively new system for calculating it.

So hopefully the documentation problems will resolve themselves over time. We have a pretty aggressive effort underway, I think both for Medicare, Medicaid, and for the CHIP program. It's really been a very high priority of the administration. I know the Secretary, is working with both the

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

private sector and public sector. There's a number of provisions in the Affordable Care Act.

There's some checks around nursing homes and providers. There are provisions about if providers have been dropped from the Medicare program that they have to be dropped from the Medicaid program and we're making that information available to states so they can accomplish that easily.

I think I mentioned before that we were doing as part of, in conjunction with our MSTAT efforts, we're doing webinars with states on initiatives. Our second webinar, the one we had actually this week, was around program integrity. We have a program integrity institute, a Medicaid Program Integrity Institute where states come in, sometimes states, often states are the teachers and we share best practices really honing in on what everybody's learning both across the Medicaid program, across states but also pulling in what we're learning and what we're developing in the Medicare program and making that available to states as we go forward.

ANDREW ALLISON: I think I have to chip in at least this much. So we put out for bid last year a recovery audit contract. It's a requirement. We were one of the probably first states to do it because our legislature asked us to go quickly and to put out for bid a contract and this was sort of

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

the contract, go find all of that you can and you get 17-percent of it.

So guess what the bids were? Six-million dollars over three years, state general fund. That's what we get back if they actually find what they projected they would find and we'd get out of the state share of 83-percent of it. You saw that our program is $2.5 billion per year. We have to have a program that is operated with integrity.

If taxpayers don't trust that payments are being made for legitimate beneficiaries, for legitimate services under legitimate circumstances, they won't fund it. We have to have integrity but if Congress thinks that we're going to get out of the structural deficit that we're facing by going after fraud and abuse in Medicaid anyway, I don't know the Medicare program, I think they'd better take a second look.

LIZZY DESANTIS: Thank you.

JIM THOMPSON: Hello, my name is Jim Thompson. I'm a retired HHS employee. My question relates to Robin's third point and anyone on the panel can answer it. Medicaid increases access to care using private providers and has to pay for that care in the costly U.S. marketplace and the latter part of this point is costly U.S. marketplace, since this is a primer, are there suggestions that you have as to other models?

I know that some of the Alliance for Health Reform briefings in the past have suggested options to working with the costly U.S. marketplace but anybody on the panel can answer this. Are there options or models that we should be considering or states should be considering? Thank you.

ROBIN RUDOWITZ: I do think that is an issue for another briefing but the point I would just say of that comment is to recognize that Medicaid is purchasing care in this private marketplace. It is not this government-run program where it's contained but Medicaid is buying services with private doctors, hospitals, managed care companies.

Ultimately to reduce overall costs of Medicaid and Medicare, there needs to be broader efforts in the overall health care system and that just working on cost containment efforts within the Medicaid program is not going to be effective in ultimately reducing costs.

CINDY MANN: Let me just add that factually, of course that's exactly right and one of the new friends on the block at CMS is our innovation center, Center for Medicare and Medicaid Innovation, which was established by the Affordable Care Act and it really is focused at ways for all payers, Medicare, Medicaid, private payers to test models and work on how to deliver care better and with less costs.

I think it's the leverage of the different payers together that really will give us the greatest opportunities to change those cost curves.

BRANDON CLARK: Yes, hi. My name's Brandon Clark. I'm a consultant with a few states. I used to work on the Energy and Commerce Committee. Just a quick question, last week, there was some discussion at the White House about giving states increased flexibility. There was a lot of discussion about how that was Medicaid flexibility and the President referenced Section 1332, the bill which is a state waiver for innovation that allows the Section 1401 and 1402 funds to be sent to the states as a block grant.

However that section does not include Medicaid funds. Does the President support not only moving the effective date of that section from January 1, 2017 up to January 1, 2014? Does HHS or CMS support including Medicaid funds in those block grants to the states? If not, why is it acceptable to send the exchange funds to the state as a block grant but not the Medicaid funds?

CINDY MANN: I don't think I would characterize the 1332 waiver option as turning it into a block grant. It is allowing states to come forward and say I have a different way of providing health care to the same number of people with the

same level of benefits and cost sharing and without increasing the federal deficit.

So it's not a block grant waiver. It's an alternate way of providing care for people alternate to some of what's laid out in the Affordable Care Act. The 1332 also specifically references section 1115 of the Social Security Act, which is the Secretary's authority to provide waivers in the Medicaid program and in fact, it requires that if a state comes in for a 1332 waiver and wants to bring in suggestions on Medicaid changes that the Secretary come up with a coordinated mechanism for dealing with a two-waiver request.

So there's certainly nothing that precludes a state from thinking about both parts together. They just have different authorities to come in by and we are certainly, would and are obligated by the law to think about them in a coordinated way if a state's interested in that.

RON HASKINS: Let me make a quick comment about the waiver idea. Waivers are much more important than some people might think they are. Welfare Reform Bill in 1996 was actually initiated by states under Section 1115 that Cindy just mentioned.

Forty-one states had waivers and what the waiver did was allow the Secretary tremendous flexibility in what he could let the states do that out and out violated federal statutes

because he had the authority to make these waivers and in the end what the Secretary did was say if you have evidence, so you had to imply some kind of data collection mechanism so you could really know what the effect of the experiment was and even if your data shows that you save money by doing this, the feds in the states would split the money.

As a result, 41 states did experiments or maybe not experiments but new programs and collected information about it and they did almost all of the major provisions in the Welfare Reform Bill that were so revolutionary and caused so much furor around the House floor and the Senate floor, had actually been tested already in the states, time limits for example, strong work requirements with what amounted to punishments for individuals who did not meet the work requirements.

So these waiver ideas are really crucial and I think it's consistent with the whole idea of federalism that a lot of people think the federal government has too much authority over the states and waivers are a way to loosen that up a little bit and let the states do some new things.

ED HOWARD: By the way, we have just a few minutes left. So if I could ask you, as we're covering a last question or two, to pull out those blue evaluation forms and fill them out for us, help us improve these briefings in the future, and

cover subjects that you'd like to see covered, we'd very much appreciate that. Yes, you've been very patient,

LARA CULKIN: Hi. Lara Culkin from the National Council for Community Behavioral Health Care and my question is more of a general one and I pose it to anyone on the panel. It speaks directly to Cindy's point that five-percent of Medicaid beneficiaries are accounting for 54-percent of Medicaid spending and I know that the, I guess the regulations, the requirements have not necessarily been completely fleshed out yet but how do you see accountable care organizations or ACOs sort of coming into this role and maybe addressing that particular point that you made about this disproportionate spending that is occurring?

CINDY MANN: I think your question raises maybe two different points. One is the theory of an accountable care organization and of course if you get 10 people in a room and say what's an accountable care organization you probably have 1,500 different opinions but certainly the theory is integrated care system of delivering care.

I think everyone would agree that integrated system of delivery of care needs to think about bringing behavioral health and physical health together. There are lots of states coming to us whether it's through regular Medicaid rules in terms of how to combine their services on their delivery

systems, whether it's through an 1115, whether it's through an innovation center or specifically as an ACO just really thinking about that integrated care delivery system.

It isn't always easy. As Andy's chart on the cost of health reform indicates, mental health services often have a separate trajectory of funding in the states and in the communities. So that makes it sometimes difficult for states to do that integration but whether it's accountable care organizations or other methods of promoting integrated care, I think that's really important. They do compose a substantial amount of the 54-percent of the expenditures.

The other thing I would just mention is there's also a health home option created by the Affordable Care Act, which gives states an extra 90-percent match rate for the coordination of care for people with multiple chronic care conditions. We think also that provides a lot of opportunities to integrate care for people with mental health issues.

ED HOWARD: Well where has the time gone? We apologize to all of you who took the time to fill out green question cards. We just couldn't get to them. So I guess the moral of that story is you really got to go get to the microphone and fight your way into verbalizing the question and to make sure that it gets asked but we are very appreciative of your

participation and remind you that we're going to do this again next Friday on the topic of Medicare.

We're actually going to be on the House side for the first time in a long time. So it ought to be a little more convenient for some of you anyway and less convenient for others. Take the opportunity to thank our friends at the Kaiser Commission for really structuring this briefing from the beginning and participating so ably in it and ask you to help me thank our panel for addressing almost all of your questions anyway in a very thoughtful way [applause].

[END RECORDING]