Briefing: Understanding Medicaid
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ED HOWARD: It's almost 12:15, why don't we get started here? Hi, I'm Ed Howard with the Alliance for Health Reform. Welcome to our program on the basics of the biggest health insurance program in America, Medicaid. We not only welcome those of you who are here in the Dirkson Senate Office Building but also those of you in congressional district and state offices around the country, and actually we have some reporters also in different parts of the country who are either listening via conference call or watching the webcast from www.kaisernetwork.org or some combination thereof. Our partner in today's program is the Kaiser Family Foundation, we're happy to have Diane Rowland who is the executive vice president of the foundation with us, and we'll hear from her in a moment. We are very pleased to have with us the Chairman of the Alliance for Health Reform, Senator Jay Rockefeller. It's really fitting that he should be here today. He is, after all, a former governor of West Virginia where he had to wrestle with Medicaid questions everyday. He is also the principle proponent of both the State Children's Health Insurance Program which has definite Medicaid connections, and the emergency increase in the Medicaid Federal Match of a couple of years ago to states that helped them weather the drop in revenues resulting from the recent recession. So, Senator, thanks for being with us, and we're very pleased to have you in charge.

SENATOR JAY ROCKEFELLER: Thank you Ed, very much, and obviously I thank above all Diane Rowland who with me, I guess this is about the thirteenth year we've been doing this, thirteenth consecutive year we've been doing the Alliance for Health Reform. It started out with Senator Danforth, Senator Jack Danforth and Nancy Kassebaum. And it's gone on from that, I've remained sort of constant and Bill Frist has been now been doing it with me for the last number of years. And it is bipartisan; if any congressman or senator shows up he or she will immediately be lifted up and carried out and deposited outside the hearing room because this is only for staff and there's a reason for that. That is that the theory, as you've heard me say many times, is that when staff gets engaged in something particularly so huge as Medicaid there are senators and there are congressmen who are into that subject, but there are many who are not into that subject, and because it's so complicated it's when their health staff become committed to it and engaged in it or further committed to it and further engaged in it that they march in and say "Look, you've got to be more of a player in this, you may not be in on Ways and Means to finance or whatever, but there are a lot of things you could do to help and that's what you ought to be doing." So, I'm grateful to the Kaiser Commission on Medicaid and the Uninsured, which is Diane Rowland, who is our next speaker. It's also an institution, but you're basically it Diane, as far

as I'm concerned. And their partnership has been for thirteen years too, so we're very grateful for that.

Medicaid, just to start this off very quickly not using any power slides, is as Ed said, the absolute bedrock of our healthcare system but often doesn't get the credit for that. It's viewed by many as kind of a niche program for people with special problems, and they don't understand it's the largest insurance program in the country. It is the fulfillment of the promise that the federal government made a long time ago to our nation's most vulnerable citizens that they will have access to affordable healthcare. It's also bailed us out on many occasions. It provides pregnant women, and children, and the elderly, and the disabled with access to healthcare. It finances nearly 40% of all births in the United States. In West Virginia it's 50% of all births are paid for by Medicaid, which will tell you something about what we deal with. Without that, obviously, pregnant women would forego prenatal visits, pregnancy related care, and other important aspects of that healthcare. One in five of our nation's children healthcare coverage, otherwise they obviously would not be covered. It pays for half of all nursing home care. It is the largest purchaser of long-term care services. Our country, for reasons which are mystical, and not impressive, has never had a long-term care policy, except through Medicaid and then there's the whole question of do people spend down in order to get eligible

for Medicaid. The Veteran's Administration, interestingly enough—we did initiate an outpatient long-term care policy there, which is gradually taking effect, but there is no long-term care, and we've seen a good deal of the effects of that in the last couple of weeks. In every state throughout our nation, Medicaid keeps our hospitals, providers and others operating. In my state of West Virginia, the average hospital, 85 percent of all revenues come from either Medicaid or Medicare.

So, I'm sure that I speak on behalf of Senator Bill Frist, our Vice–Chairman when I say that Medicaid is a focal point for congressional agenda this coming year. This is due in part, obviously, to the fiscal pressures on the states as well as the rapidly rising costs of healthcare. But let a word be said about that: If it weren't for Medicaid, there wouldn't be 44 million uninsured Americans, there would be 50 million uninsured Americans, and Medicaid turns out, in fact, to be an incredibly efficient program, as compared to anything else comparable. The only program I know which is more efficient is Social Security which has a one percent overhead. Some say one and a half percent, some say a half percent, but it's very, very low. Between 2000-2004 when all kinds of explosions were taking place, Medicaid was four and a half percent it cost to run it, and when you think of all the states, all the distribution, that's not bad. Medicare was 7, 7.1 percent, and

the private sector averaged twelve and a half percent, 12.6 percent to be precise, so, when you think of Medicaid, you have to think that it's efficient, and it's not a particular waste. It's also important to mention that the two main factors contributing to the Medicare cost grow are the decrease, which has been going on over a period of years of employer-sponsored healthcare coverage. People are just more and more easily walking away from that, or in some cases using bankruptcy as a means not to do it, or they simply can't afford it. In any event, it's been cut back or copayments on the part of workers are going up or it just stops altogether.

And then the other thing is the question of long-term care. Long-term care has just risen humongously. Just to make the point about the uninsured, between 2000 and 2003, 4.8 million people lost their employer healthcare coverage, 4.8 million. During the same period, Medicaid enrollment increased by 5.8 million, which kept that number of uninsured in this country at 45 rather than the approximately 50 that it would have been. The long-term care I've already discussed. The Medicaid program actually spent nearly $40 billion on uncovered Medicare services in 2002, so Medicaid just scoops up all kinds of things and does them, and doesn't get a lot of credit for it.

In addition to healthcare costs, the Medicaid debate also is what kind of flexibility will governments have? As Ed

indicated, I was a former governor, and I certainly understand the need for flexibility, and the need for flexibility is particularly good when you have money to spend. There aren't many governments that have much money to spend, and there is something called the Department of Health and Human Services Waiver process, which is used broadly and widely by states and they have been able to do this, so they have a certain flexibility. Speaking on a personal basis, Senator John Chafee, the father of present Senator Lincoln Chafee, and several of his. . .wrote the Children's Health Insurance Program, and at that time the governors came in and pleaded for their being able to control it, i.e., state flexibility or state ownership. John Chafee and I were just adamantly against that because we knew that there were some governors who cared about it, and some who didn't care about it, and we were quite right. It should have gone directly to Medicaid. The S-CHIP program should have gone directly to Medicaid, which would immediately put it out across all the states without any increase anywhere, and in our state and a number of states, it's taken a number of years to get that going successfully.

Today, I think the briefing will shed a lot of light on a lot of aspects of the Medicaid program, but the briefing will also offer some insights into people who benefit from this vital program. During the Senate budget debate on Medicaid, the argument was made that a $15 billion cut to the program is

insignificant because it would only reduce Medicaid spending by 1 percent. Well, in the Senate, at least, we rolled that budget cut back by a 52 to 48 vote, but the House did not, and we have yet to meet in conference. What will happen there is uncertain. So, if you just say it's one percent, then you have to turn that to, well, what people are you going to cut out or cut off? That's a lot of people, and nobody else meets their needs, and Medicaid is rising for a reason. People need it. So a cut is not as simple as a budget number, and that will be discussed by the folks here today.

I thank you all very much for attending. As you know, we have a little system where we each speak for a few minutes, and then we open up to questions and answers, and we try to get some good arguments going. I guess Ed will introduce everybody. I wanted to introduce Diane, but you seem to be in full control of that situation, so you—[laughter]. I praised Diane; you introduce her.

ED HOWARD: Well, Senator, I don't want to gild the lily, here. This microphone, I'm gonna have to get right up next to, it looks like. Before I introduce Diane, I just wanted to make sure that the logistics of this, which are a little different from our normal briefing, are clear to everybody. Those of you in the room can see the microphones you can go to to ask questions at the appropriate time, and there are some green question cards you can fill out, and a

blue evaluation form. I want to say to those people who are watching the webcast or listening on the conference call, that if you lose whichever one of those components you're doing with, you can switch to the other. You can go to www.kaisernetwork.org if you're in search of the webcast, and if you have to start listening to the conference call, the number is 1-800-256-8682. And if you go to the Alliance website at www.allhealth.org, all of these numbers and instructions are there, so you can click on them and not have to worry, including instructions on how you can ask questions once we begin that part of the program, which as the Senator said, is really why we're here today.

We do have Diana Rowland with us from the Kaiser Family Foundation. She's Executive Director of the Foundation as well as, as the Senator pointed out, the Executive Director of the Kaiser Commission on Medicaid, and just, oh, by the way, one of the country's leading health policy analysts, so it's very fitting that we have her there, both as cohost and expert to lead off this panel discussion. Diane?

DIANE ROWLAND: Thank you, Ed, and thank you Senator, for your opening remarks. I think today is a very important basic briefing on a program called Medicaid that will mark its 40th anniversary this July. It is probably not only one of our largest healthcare programs, but also one of our most complex, and we hope today to shed some light on the complexity and the

organization of the program. It was enacted in 1965 as I said, as a companion to Medicare, and what you will see today is that it has been a very good companion to Medicare, filling in many of the gaps in that program, and making that program really work for some if its lowest-income beneficiaries. It is a federal matching program, giving grants to the states, so it is jointly financed by the federal government and the states, and it really began originally as a program focused on the welfare population, but has been growing tremendously in terms of filling in the many holes in our healthcare system over its 40-year history, today covering 52 million people, 39 million who depend on the program for their health insurance coverage, but another 13 million who depend on it for assistance both with their acute-care needs, and filling in some of Medicare's gaps in acute-care coverage, as well as providing essential long-term care services. Over six million people on the program are Medicare beneficiaries who rely on Medicaid as a wrap-around program, and as a program, it covers some of our sickest on most costly Americans, therefore incurring a cost of some $300 billion. As the Senator said, it covers one in five healthcare dollars today, and one in two long-term care nursing home dollars.

If you take away the program's complex descriptions of eligibility, I think it's easier to see what a role it plays for selected populations. It covers about 40 percent of the

poor, does not cover all of the poor because its historical welfare roots have left childless adults out as one of the groups eligible for insurance assistance. It covers over a quarter of our nation's children and 50 percent of low-income children. As the Senator mentioned, it's a major source of coverage for pregnancy and births in America. It covers 18 percent of all Medicare beneficiaries, 20 percent of people with severe disabilities. It has been a major in our efforts to deal with our domestic AIDS crisis, covering 44 percent of people living with HIV/AIDS, and today covers some 60 percent of all of the two million people in nursing homes. It is a program where the federal government requires certain groups and eligibility levels to be covered and leaves the states with options to cover others. Here you see that the income standards required for eligibility, because this is a means-tested income-related program, vary depending on the type of person or situation you have. We now require that all states cover children up to the poverty level—which is about $9000 for a single person and $15000 for a family of three—and cover pregnant women and young infants at a slightly higher level. Elderly people and people with disabilities are generally covered as a requirement if they are recipients of cash assistance through the Supplemental Security Income program, and that eligibility level is at about 74 percent of the federal poverty level, and as I said, unless they are disabled

individuals who are without dependent children, are generally not eligible, and certainly not required by the federal government to be covered, no matter how poor.

It is also a program that gives the states great flexibility in terms of the range of services and benefits that they can be covered, very much different than what would be available through a private health insurance plan. It covers those basic medical care services and mandatory services, such as physician services, inpatient hospital, but where it is different than private insurance is in its range of services that meet the needs of people with disabilities and the long-term care needs, so rehabilitation services, dental services, a lot of inpatient long-term care services as well as increasingly home and community-based services are all part of the benefits that Medicaid offers at state option that are not required by the federal law, but that have become essential to its role filling those gaps in long-term care where there's no other program or place for people to turn once they exhaust their means to pay for long-term care on their own.

If we think about how the program operates, we can look at the dollar expenditures, and we see here that a little over a third of all program spending is for long-term care, about 58 percent for acute care, and we are also seeing here that we're increasingly seeing payments to managed care organizations. As a component of spending, that's now about 15 percent. So while

Medicaid is a program that publicly finances care, much of that care is delivered through private organizations, managed care plans, as well as through payments to the private healthcare system. It is not a federally operated or state operated system of delivery; it is a financing system that is public, purchasing into the private sector.

What I like to think about when I look at this slide is, this tells us the story of the challenges in Medicaid. While half of the enrollees are the children that are covered, nearly 70 percent of the spending is for the elderly and the disabled, who account for that large percentage of spending because of their greater us of healthcare services and their long-term care needs. So when one looks at making changes in the program, you can quickly see that to reduce eligibility for children will not ultimately save you much in expenditures; where the coverage is the most expensive is for the elderly and disabled. And that's really depicted again here, if we look at individual per capita spending, where the per capita spending for a child on average is $1700 a year, most of that for acute medical care and preventive services, and the expending per elderly person to supplement Medicare—remember Medicare for them is already providing basic medical care—is $12800. Of that, about $1000 is for prescription drug coverage for the low-income elderly that Medicaid provides, and that will, of course, be replace in January by Medicare, but I'll leave

Rodney to talk about some of the implications of that for the state. But nonetheless, you see what a toll long-term care takes in terms of supplementing Medicare for the elderly, where it's the major source of their per capita expenditures.

The federal government matches the state expenditures, as I said, on average picking up 58 percent of the program costs, but the rate at which the federal government matches expenditures varies by the per capita income of the state, providing greater assistance to the states with lower overall income, so that it now ranges up to the highest being 77 percent of all dollars. This means that for every dollar a state invests, it gets at least a dollar in additional financing from the federal government, which makes this a very strong economic engine in many of the states in terms of supporting the healthcare system.

Briefly, I'll just close with the three major roles of Medicaid: As we've talked about, the first role has been as the health insurer for low-income children, doing better for low-income children, but we still have more outreach and more enrollment gaps to meet—covering some of their parents, but eligibility levels for parents are extremely low compared to the standards we've seen for children with Medicaid, and then the State Children's Health Insurance Program, now covering most children up to around $31000 for a family of three. The parents themselves are covered at less than $8000 in many

states for a parent to be eligible, and very few adults without children being covered unless they qualify as people with severe and permanent disabilities.

The second role of the program has been to fill in those gaps in Medicare for Medicare beneficiaries, and you see here that it provides both coverage for dual-eligibles that are full, where it provides long-term care, medical fill-in, premiums assistance and cost-sharing, and then there are others for whom the program covers at least their premiums under Medicare and in some cases their cost-sharing, but not supplemental benefits. But this is a role that many of the states have raised as one that contributes to their costs, where they're looking at the aging of the population and concerned about what the ultimate impact of this coverage will be.

And finally, as we struggle as a nation with an aging population, we need to face the reality that we really have not got a comprehensive system for providing and meeting our growing long-term care needs. Here you see Medicaid picks up about half of nursing home care, and about a quarter of home healthcare, but it is really the only source of assistance for people who have ongoing custodial care needs, and is one in which families are required to spend down to establish their eligibility for Medicaid, leaving their resources to be used up before they can become eligible, and then continuing to

contribute on a monthly basis whatever income they have available for their continued Medicaid coverage, so that, while 60 percent of the residents of nursing homes are on Medicaid, Medicaid only pays for 46 percent of the bill because they're still included in much of that out-of-pocket spending.

So it is these various roles of Medicaid that we're going to try to help you understand more, how the program came to provide this coverage, and what some of the issues are around the future. We think that you need to bear in mind that in these various roles, there are people at stake, and these people are some of the sickest, the poorest and the most in need of our assistance. I'd like to say that what Medicaid is is the program that fills the holes in our healthcare system, our lack of universal coverage, our lack of any way to support and assist people with their long-term care needs, and the gaps in the coverage of Medicare for its beneficiaries. As those holes grow bigger, the role of this program has grown in part, to answer those holes. Thank you.

ED HOWARD: Thanks very much, Diane. Next we turn to Rodney Whitlock, who's new to the Majority Staff of the Senate Finance Committee, but certainly not new to Medicaid and related issues. He was the Health Policy Advisor, among other things, the Deputy Chief of Staff for Representative Charlie Norwood, who's been at the heart of some recent debates on patient's rights, and Medicare Prescription Drugs and liability

reform and a whole range of other topics. Rodney, thanks very much for being with us.

RODNEY WHITLOCK: Thank you, very much, Ed. I'm honored to be here with you all. I'm going to try to direct most of the remarks I make today, particularly on the structure of Medicaid and the financing of Medicaid, more towards the people who are back in the states listening to this, with all due respect to the people in the room here, [clears throat] and to hopefully capture a few of the issues, particularly that you may be hearing back home about Medicaid and to give you a better understanding of some of the conflicts that often arise in Medicaid.

Medicaid, as Diane laid out, is a federal/state partnership that provides healthcare services for certain populations, and it is administered largely by the states with federal direction, funded from both the state and federal funds. It is very different from Medicare in that respect. Medicare is generally speaking, a federally directed program, with all decisions regarding the program being made at the federal level here in Washington and the mother-ship in Baltimore, where Medicare is housed. Medicaid is different in that respect. Medicaid is generally administered at the state level. The states make most of the programmatic decisions with influence from the federal government. Now, for those of you who are wondering where some of the sources of conflict arise,

there's a very early one, which is the battle between the states and the federal government over exactly how much influence the federal government should be able to exert over a program that is largely administered at the state level.

Under Medicaid, states are required to cover certain populations, and we refer to these as "mandatory populations." They also have the ability to cover populations outside of mandatory, which we refer to as "optional populations." That, again, is a source of conflict, which is, the ability of states to cover optional populations often involves input and consent from the federal government. Allen, I think, in his presentation will go into that in further degree. This is a condensed version of Diane's Page 5 Chart, just getting into some of the ideas of what is mandatory and what is optional.

Moving into the structure of how Medicaid is paid for, essentially, Medicaid is a partnership with the federal government and the states splitting the costs of the program. How much money the state receives from the federal government is determined by a formula, where the federal government will match the amount of money spent by a state. This match, as we talk about, is the Federal Medical Assistance Percentage, often known as FMAP, and it determines what is the share of the states' Medicaid program that's paid for by the federal government, and then what is the share of the states. The FMAP is calculated by taking a rolling three-year average of a

state's per capita income. I actually went into the code to see if I could put up actual numbers up here, but it's way too complex, and I would butcher it if I tried, so we'll just say again, that it is a rolling three-year average of a state's per capita income. In theory, this number is supposed to accurately capture the fiscal health of the state. How much is the FMAP? The average is 57 percent, and that means for every 43 cents a state spends, the federal government sends the state 57 cents. The highest, for the 2006 estimates, is Mississippi, at 76 percent. There are 12 states that have the minimum, as Diane represented, meaning that at least half of the program is paid for by the federal government, of 50 percent.

Okay. Now, the Federal Medical Assistance Percentage is controversial in this sense: Since the FMAP represents a state's fiscal health, when a state's doing poorly economically, it should receive increased federal funding. When a state is doing better economically, it should receive less funding from the federal government. In that sense, Medicaid is what we call a counter-cyclical program. When times are good, the states should not have to spend as much money on Medicaid, and should have more money of their own. In theory, the states' tax income should be much higher, and so they should be better able to fund their own Medicaid programs. When times are less well economically, the state is not receiving as much in terms of tax revenues, and therefore is dependent

further on the federal government and should receive more in terms of federal funding. One of the complexities about the FMAP and sources of controversy is over whether or not the FMAP actually meets the states' needs, and that states are going to be able to adequately fund their Medicaid program with the monies that are coming to them from the FMAP. We will likely see that become an issue here shortly, as current projections for the 2006 FMAP show that 29 states will be receiving decreases. Now, again, for those of you back in the states who are watching this, that means that 29 states are going to receiving less money from the federal government. Now, many states have to balance their budgets. Any time the FMAP goes down it does create some fiscal difficulty back in the states, and so, while the numbers for the FMAP are supposed to be a reflection of improving economies in the states, that may not necessarily be viewed as such by the people back home who have to make their budgets for their Medicaid programs.

Talk for a minute about the growth of federal Medicaid spending, just to give you a sense of the program and its scope, particularly over the next ten-year window. Working from data provided to Congress by the Congressional Budget Office, over the next ten years, Medicaid is going to grow from the federal share, which is $190 billion, to almost $390 in the year 2015. It's growing on average by seven percent and is going to just over double over the next ten years, and that's

it, represented graphically. Its enrollment is also growing as well, such that in the year 2006, CBO estimates that Medicaid will serve 58.6 million people, and 63.9 in 2015. It's growing on average by one percent with a nine percent growth over the next ten years. And again, there's the graphical representation.

Now, one area where Medicaid is going to undergo change in the benefit side—this is my segue to Alan—that currently Medicaid does cover prescription drugs for certain populations in states where they have chosen to do so, and that would be in Medicare-eligible individuals. The Medicare Modernization Act, MMA, also known as the Prescription Drug Bill, will transfer the responsibility of covering drugs for Medicare-eligible populations so that Medicaid will no longer cover that. That is a responsibility that the states will no longer bear, and will become that of the federal government. But even that has its complexities as to how states try to figure out exactly how that's going to work, which I believe is something Alan's about to cover.

ED HOWARD: Thank you very much Rodney. Alan Weil is our next speaker. By the way, I'm not doing justice to any of our speakers. There is biographical information about them all in your packets. One of the things in the packets is an article Alan wrote a couple of years ago for Health Affairs, in which he described Medicaid as a program that is "loved by few,

denigrated by many, and misunderstood by most." He's here to clear up at least the third part of that dilemma. He's now the Executive Director of the National Academy for State Health Policy. He's former cabinet member from Colorado in charge of Medicaid, and headed the Urban Institute's assessing the New Federalism Project for about seven years. We're looking forward to the misunderstandings being cleared up for us, Alan.

ALAN WEIL: In ten minutes or less. Thank you, Ed, and thank you, Senator Rockefeller, for your ongoing leadership with the Alliance. It's sessions like this that hopefully reduce the degree of misunderstanding about these programs. I've been asked to address two issues, waivers and MMA, and how those two play a role for states. I speak often and this time I got some direction that I've never gotten before as a speaker, so I want to share with you that panelists were asked to stick to accepted facts about the program and refrain from making judgments on policy questions during structured remarks, so I will try to be appropriately bland [laughter].

With that in mind, there are three types of waivers you should be aware of if you're interested in the Medicaid program. Section 1915B of the Social Security Act allows HHS to waive three requirements of the Medicaid statute: statewideness, which as its name suggests, without a waiver you must run a uniform program throughout your state. If you want to try something in a region of the state, you do need a

waiver. Comparability requires that you provide comparable benefits to all of your Medicaid recipients within two broadly defined categories. If you wish to target benefits to one group or another, you need a waiver. And freedom of choice is probably what 1915B waivers are best known for. Under the Medicaid statute enrollees have the right to choose their provider. If you wish to constrain that choice in any way, a waiver is required.

Section 1915C waivers are known as home and community-based services waivers, or HCBS. These are the waivers that states use primarily to provide social supports and other services that enable people with long-term care needs to remain in the community.

And Section 1115 of the Social Security Act is for research and demonstration waivers. It's important to note that Section 1115 waivers are not just for Medicaid. They extend to CHIP, to the Taniff [misspelled?], to the welfare program. It's a broader degree of authority for states that wish to pursue either research projects or to demonstrate innovations consistent with the statute.

One aspect of waivers that tends to receive a good deal of attention is the requirement for budget neutrality. Waivers must be budget-neutral to the federal government, but it's important to note that this does not appear anywhere in the statute, it's simply a matter of long-standing federal

government practice. When states oppose waivers, and particularly states that require expansions, they have to find savings to offset those expansions, and the traditional sources for finding those savings are in managed care, which over the years has been shown to reduce costs, to reprogram funds that would have otherwise been spent through the Disproportionate Share Hospital program, or DISH. Recently, states have been reallocating their unspent CHIP funds and using those as a resource to make their waivers budget-neutral, and under the new HIFA—Health Insurance Flexibility and Accountability waivers of the current Administration, states have been authorized to scale back benefits to some populations in order to extend them to others.

Waivers do play a very important role in the Medicaid program. They were central to the advent and spread of managed care in Medicaid. Without waivers, managed care was not possible, and now managed care is routine within Medicaid. Waivers have completely redefined the scope of long-term care services within Medicaid. Medicaid retains its historical institutional bias towards nursing home services, but through waivers, states have been able to greatly expand home and community-based options for their enrollees. Waivers have enabled expansions to otherwise ineligible populations, most notably, as you heard earlier, adults without custodial children are not eligible for Medicaid, but with waivers, so

long as they can come up with the funding, they can, and some states have covered portions of this population. And some of the more innovative approaches to Medicaid that have gained fame over the years, I supposed today the more publicly noted example would be Ten-Care, but historically, approaches like Oregon's effort to set priority, diagnoses and treatments has all been under the purview of Section 1115 waivers.

Without getting into the realm of making judgments, I will say that states have some thoughts about waivers. It is long-standing policy of the National Governor's Association that if one state receives a waiver and successfully implements it, other states should be able to replicate that waiver without having to go through all of the review processes required for new waivers. The most common term governors use to describe applying for a waiver is to come to Washington on bended knee. And governors object to that metaphor, as they seek permission to run their programs as they see fit and as their citizens suggest that they should. Over the years, because of the long processing time for waivers, there have been various efforts to create timelines. If the CMS or before them, HICFA doesn't respond within 30 days, 60 days, the waiver will be granted. These efforts have never succeeded because there are always ways to stop the clock, and so the processing of waivers continues to take some time.

Let me turn to the second topic, which is the Medicare Modernization Act and the role of states. States basically have four roles with respect to the MMA: First states are large employers, and like all employers, particularly employers who offer retiree benefits, states are affected by the provision of prescription drug benefit within the Medicare program.

Second, Medicare under Part D now has a means test for the subsidies within Part D and states have a role in conjunction with the federal government in administering the income and asset tests included in the statute.

Third, states are now funders of the Medicare program. By statute, states must send check to the federal government to cover what were anticipated to be the savings, or a portion of the savings states would receive as Medicare picked up the cost of prescription drugs. This is commonly and affectionately known as the claw-back.

And fourth, states administer their Medicaid programs and the change in Medicare has substantial implications for Medicaid. Now, these first three roles are very important, and particularly the third of the four, claw-back, has received a good deal of attention, and I think it’s safe to say that many states believe that they will lose money on the deal, but we don’t know that, because the time has not yet passed to give us

the evidence we would need. But I'm going to focus on the fourth, because this is Medicaid 101.

The most important change from states' perspective with respect to Medicaid and the MMA is that on January 1, 2006, six million so-called fully dual-eligibles who have received their prescription drugs through the Medicaid program will no longer be eligible for Medicaid drug coverage. That benefit will be eliminated, and those beneficiaries will receive their prescription drugs through the new Medicare Part D benefit. We throw around the term dual-eligibles a lot, and just so you understand that these are, as Diane alluded to earlier, the sickest and the poorest of the Medicare and Medicaid beneficiaries, half of them in fair or poor health, 71 percent with incomes below $10,000, much more likely to reside in an institutional setting than in the community, and to have ceratin health conditions that make their care expensive and complex. And so at the risk—and I think this is the closest I'm making to a judgment this afternoon—let's just say that states have some concerns about how they are going to respond to the changes in Part D.

I do want to spend a moment on these. Of course we don't have any data because the shift hasn't happened yet, so I'm just reporting the facts, which are that there are concerns, which isn't to say that these will all be realized. First concern from the state perspective is that the timeline

for assignment of dual-eligibles to Medicare plans is rapid. By rapid, what we mean is six million people in six weeks. States have a good deal of experience with auto-enrollment of their Medicaid enrollees, not those as complex as the dual-eligibles, into managed care, and I think it's safe to say that most states have learned that when you auto-assign into plans, fast is a recipe for problems.

Second, a concern is that some enrollees may not be able to navigate this new system. These are enrollees who are accustomed to a particular way of receiving their benefits that has been fairly open-ended, but they will now move into a new and privately-based system that they may or may not be able to understand. States will not obtain any information about the drug utilization of enrollees, so while they continue to be responsible for all of the Medicaid benefits other than prescription drugs for this population, because they won't be paying for these services, they will not know whether or not people are getting their medications. Therefore, from the state perspective, the risks associated with this transfer are substantial.

I do want to be clear in closing that this is states' concerns with respect to the dual-eligibles in Medicare/Medicaid. I'm not trying to suggest that states have a negative opinion about Part D in general, and I think they're very understanding of the benefit, the new benefit that's being

offered to many Medicare beneficiaries who otherwise would not have drug coverage at all, but for those who have been in Medicaid, there are some concerns about this transition.

ED HOWARD: Fact-filled. Thank you. We're now at the point of this program that we want you to ask questions. As I said, there are green question cards for those of you in the room, and microphones both at the front and the rear of the room that you can use to ask them in your own voice. Those of you who are watching or listening to this program from outside of Washington, we're channeling your questions through the Alliance. Our phone number is 202-789-2300. You can also e-mail your question to frontdesk—all one word—@allhealth—also all one word—.org (frontdesk@allhealth.org). And, if you have a green card with a question on it, hold it up and someone will snatch it from your hand.

I should encourage the other panelists, if you've heard something that triggers a comment, or a clarification, you should feel free, and Senator Rockefeller, if you want to put any of these folks on the grill, you can do that, too. Yes, we have a question in the back.

BRIDGET TAYLOR: Yes, hi. My name is Bridget Taylor and I work for the Energy and Commerce Committee ranking member, Mr. Dingle [laughter]. I keep hoping, I can't help it. I just have a question, because both Rodney and Alan talked a lot about what the states' role is, and how the states are

concerned about this and how the states manage the program and everything. I wonder, given that most of what the federal government requires now are things just that are uniform, like the level of benefits, number of people covered, who are mandatory, but they give them a lot of flexibility on optional populations and other things like that. Do you all—maybe Senator Rockefeller might want to answer this one too—Do you all think there's too much of a requirement by the federal government given that we put in over 60 cents on the dollar on average for everything that we do?

SENATOR JAY ROCKEFELLER: I'm not meant to have opinions [laughter]. Bill Frist and I maintain this policy. We have throughout the years, but my answer is no. In other words, if you thought it was too much, I don't think the answer—in fact, one of the things that I was kind of musing about goes back to Diane's presentation is the word optional because it's a fascinating word. I'm not quite sure who invented it, but you have the mandatory items and you say, "Well, that's Medicaid. That's Medicaid." But then you have these optional things, like a chocolate soufflé or something off there. And then you look down at what they are—they're prescription drugs, and all kinds of things, and the important factor—which was important in the budget debate—is that the optional cost of Medicaid, if I'm not incorrect, Diane, is about two-thirds the entire cost of Medicaid. So the word

option is one which I found interesting. I did not answer your question, but said what I wanted to say.

ED HOWARD: Yes, Rodney?

RODNEY WHITLOCK: I think—where'd Bridg go? I can't even see him anymore. There you are! Hey, Bridg! I think that one of the things we do face as we're looking at Medicaid right now, is a question of rationality of the policy, and trying to determine the difference between what is a federal requirement and what state options we should have. But I think we may well be to a point where I think it's appropriate to step back and look at—I mean, Diane's Figure 5 chart. I mean, determining what is mandatory, what is optional, and why? And how those decisions are being made. Particularly I know that you, and Alice is sitting beside you and she's hiding—that we've talked about what is being, how the waiver process is being used, and how that process is being used to determine what can be covered, what is allowed, what is not allowed, and is it being appropriately used? And so I think it's that your question generally is, should the federal government take a more active role? Should it be the policies we pay as much as we do. What should we be doing, I think may be the baseline question there. Should we pay as much as we do? What should we be doing, I think may be the baseline question there.

Certainly over the history of the program, we've known that where you have an option, it's mostly because the states

have argued that they can't all afford to do it, or they don't all want to do it, and clearly, we've also seen that where the federal government has put requirements in, like that all children up to the poverty level be covered, that's been a very important mechanism of using federal dollars to establish a floor across the country, and I think that really is the issue. Where do we want to have a floor in return for the federal dollars, versus give states the ability when they don't have as much revenue to put up a broadened program to provide optional coverage, but I don't think there's any such thing as an optional person, or when someone needs medical care as an optional service.

ED HOWARD: We've got a question on a card that actually is directed to Rodney. It might have come from somebody in South Dakota as opposed to somebody in the Dirkson Building. And they want to know what those 29 states are who are going to experience decreases in their federal matching percentages next year.

RODNEY WHITLOCK: I do not have it with me. I think if you go to either CMS's website or Social Security's, because one or the other is where I found it. You can go do the work from there. Or if that person, whoever it is, wants to send me an e-mail, they can do so as well. That's probably in the bio-packet, wherever. Then I'll look at that for you.

ED HOWARD: And when you get it, if you give it to us, we'll make sure we post it on our websites as well. There are a number of questions on this one card about waivers. Ordinarily you wouldn't want four questions on the same card, but they're all sort of inter-related. What impact are home and community-based waivers having on reducing the institutional bias in Medicaid for the elderly and people with disabilities? Are states expanding the use of those waivers? How detrimental is the requirement for budget neutrality? And, do you think we'll ever see the day when you have to get a waiver for institutional care as opposed to a waiver to stay in your own home? Alan, you want to take a crack at those?

ALAN WEIL: The easiest of those to answer is the second, are states expanding their use? The answer is yes. I don't have a slide, but you can look at the trend lines in spending on institutional and home and community-based services and the number of people served by them, and it shows that quite clearly. The waivers definitely help shift the focus of the program and help reduce the institutional bias. The requirement for budget neutrality is not exactly a detriment in this area, as opposed to in some other aspects of waivers, at least today. There used to be some rules around budget neutrality. One of my favorite Medicaid terms was the "cold bed" rule, that is that no longer exists. But today, states are concerned as much as the federal government about opening

the door widely to home and community-based services because of concerns about what's known as the woodwork effect, which is that if you offer only nursing home benefits, a lot of people who could use some help won't take you up on those benefits because they're not interested in being in a nursing home. If you offer home-based services and community-based services, there are a lot of people who would benefit from someone helping them—homemaker services and things like that—and so you worry that they'll come out of the woodwork seeking those services. So states are interested in capping the number of people who can be served through these waivers, and I would say that interest is shared by the states and the federal government for budget reasons, so I don't think it's a federal budget rule. Primarily, that is an impediment, although I know in some states it is. I don't think we'll see a day where you need a waiver for institutional services. However, there are plenty of people who are talking about trying to put institutional and non-institutional services on an equal footing. That is not an easy thing to do, but it is of sufficiently great interest to enough people that I think we could get ourselves to that point.

ED HOWARD: I am reminded by that string of questions of something I should have said in the beginning, which is, the whole point of this exercise is to get at your basic questions, so don't worry if it seems simplistic or obscure; ask the

question. That's why we have such luminaries up here with which to respond to your questions. Here's a fairly straight-forward one on a card. As enrollment in Medicaid increases, are the numbers of elderly increasing more rapidly than other populations, and if so, how much more?

DIANE ROWLAND: Actually, most of the enrollment growth in Medicaid recently has come on the part of children and some of their parents, in part due to the fact that when we have an economic downturn, more people fall into the lower income groups and lose their employer-based coverage and turn to Medicaid for assistance. The disability group is growing somewhat more rapidly than in the past, but the elderly have stayed pretty much stable in terms of enrollment. That's not to say that the cost side of the equation has been that stable, because overall in this nation, healthcare costs are going up and Medicaid is facing those for its population.

ED HOWARD: A question about the dreaded claw-back you mentioned, Alan. What's the amount or percentage that states are going to have to pay back to the federal government for the new drug benefit?

ALAN WEIL: Okay, I am not a claw-back expert. There is a formula based on historical spending, and I think the primary reason states are concerned that the formula will require them to pay back more than they would have otherwise paid is because prescription drug costs have been growing

rapidly. For a number of years states have put into place some cost-containment methods and many of those ideas and methods were only implemented and thought of after the base year, and therefore, if they've been able to bring the rate of growth down, that's not reflected in a formula. The actual percent and base, how that's calculated, I'm afraid I don't carry that I my head.

RODNEY WHITLOCK: And neither do I, but I think the important following to what you just said is that it is a phase-down over time until it phases out completely, so states theoretically should be paying less and less each year until at a point in time out in the far-distant future, certainly from the state perspective, it will eventually become zero.

ED HOWARD: And we'll volunteer to collect some information about the claw-back formula, and the claimed impact on various states and put it on our websites within the next few days. We have a question about intergovernmental transfers. We didn't hear any of that in the presentations, but the question reads, as such: The Administration and HHS have said that there are many states inappropriately or illegally using their Medicaid funding via intergovernmental transfers. Congress has asked the Secretary for a list of these states. Recently the Administration has proposed a savings to the Medicaid program in the budget, a savings that would be made if Congress or HHS stopped these improper

financial transfers. Is that a judgment? Secretary provided a list to the Senate Finance Committee, but they have not shared it with the public, so the question is, what is going to happen next? And Mr. Whitlock, won't you release this hit list to the public?

RODNEY WHITLOCK: You couldn't let that PS go, could you, Ed [laughter]?

ED HOWARD: I didn't make it up.

RODNEY WHITLOCK: I do not have a copy of the so-called hit list. I have not seen one. I've heard of its existence. Generally, to the issue of intergovernmental transfers, I think that the question is historically there have been some cases where money being used from federal Medicaid funds or certainly state Medicaid funds were going places it should not have gone, and I'd like to think there's at least somewhat agreement that Medicaid shouldn't be going to roads, bridges, stadiums, et cetera; it should go to Medicaid beneficiaries. And so, that is the core issue that has historically created concerns about intergovernmental transfers. Should that policy now be refined to more specifics, the Administration has certainly spoken towards that in their budget. CBO had a hard time understanding it, and was not able to come up with a score related to the policy that the Administration was trying to suggest. Where we as the Finance Committee and our role in looking at IGTs, I think one thing we do have as a concern is

understanding whether or not any policies regarding IGTs are being administered in a uniform way, that certain states are being shut down on IGTs while others are being allowed. And that's something that we need in the minimum to be concerned with in that level. So, in terms of the specific hit list, I don't have anyone to help you with right at this particular moment.

ED HOWARD: Alan?

ALAN WEIL: I of course can't speak to the hit list. It is a sort of sad day when IGTs make it into a Medicaid 101 discussion. This ought to be a graduate course in Medicaid if we're going to get to this. I think it is important to understand that first of all, the notion that intergovernmental transfers are illegal is a fairly odd concept here. It is long-standing practice in some states to rely on levels of government other than the state, particularly localities, to participate in paying the state's share of the Medicaid program, and that is a reasonable and not particularly controversial thing for states to do. The only point I really want to make in response to this question is, as we throw around the terms of IGTs and their other companion terms, disproportionate share of hospital program and upper payment limit, and certified public expenditures and the like, these are all real things that are real ways that states can and appropriately should pay for their Medicaid programs. But what

is troublesome is when it appears that states are engaged in what look more like paper transactions than real expenditures, and although some states have pushed the boundaries of what they're permitted to do under federal law, just as happens in lots of areas of the law, it's also the case that I think most states would welcome clarification and certainty with respect to what the federal rules are going to be, and particularly are interested in a prospective approach to these issues as opposed to going back and revisiting plans and approaches that the federal government already told the state were acceptable. A fair discussion about how the financial and fiscal integrity of the program can be maintained or improved is one that I think many people would welcome, but it does need to be based on understanding that in many instances states are doing exactly what the federal government wants them to do in terms of using legitimate sources of funds to raise the money to pay for their share of the Medicaid program.

SENATOR JAY ROCKEFELLER: Let me add a comment on that if I could. I remember 25 years ago, West Virginia was one of the first states that sort of started that scam, and it was a problem for a while. Medicaid money was abused. I was not governor, I hasten to point out. But, it was a problem, and it was a problem because it was a fairly new source of creativity on the part of enterprising governors, and everybody needed money, and the federal government had a lot of it at that

point. But I think that pretty much except for the intergovernmental transfers, all the ways that that can possibly happen have been eliminated by Congress. I don't think that there are any of the creative ways that were used to abuse that system that remain, unless any of the panelists contradict me, in which case, they'll probably be correct. But I don't think that that is any longer a problem, except for the intergovernmental transfers.

I want to make another comment. And of course, part of that money is going to come back with this so-called claw-back, and the 29 FMAP changes. I know in West Virginia's case, what we're going to have to pay is going to rise by two percent and what the federal government is going to have to pay is going to decrease by two percent, which is not exactly the trend of the way things are going in West Virginia, but that's just the way the math works out, so that will be an absorbed cost, which you can say in some ways would have West Virginia returning money to the federal government.

I want to go back on this optional, because I think the optional is really important, because in the Finance Committee we had a lot of hearings on this, and people would come before the Finance Committee and they would say, "Well, I have always believed and I still do believe that there should be no cap on Medicaid items and services, that is, the real Medicaid." And then it would take, actually, a fairly careful observer to say,

"Well what about the optional part?" And the reason it would be difficult would be that the optional wouldn't seem to be terribly important. I mean, you look down here and you see hospice services, and clinic services, and inpatient facility, psychiatric home health services, as I mentioned, prescription drugs, a lot of other things. And, when the follow-up question was asked, "Well what about caps on optional services?" "Oh, well that's a different thing," came back the answer. Therein lies, I think, a major moral question, and that is, what is what affects people more than other people. What—and I think the panel has suggested this—there ought to really be a new working out of what is optional and what isn't, what is Medicaid and what isn't, or even a renaming of the word optional. But it was very confusing, and many members of the Finance Committee didn't understand that at that time, so the person who gave the testimony got away with it by claiming that he said there would be no cap on Medicaid, and it wasn't until the second hearing that somebody asked, "Well, what about the optional?" and he said, "Oh, well, that's different." So, that I think, is a very serious problem in the future of Medicaid.

ED HOWARD: Yes, Sir? You want to identify yourself?

JESSE BUSHMAN: My name is Jesse Bushman and I work in the Legislative Office with CMS. I had considered asking the luminous Rodney Whitlock to exercise speed and fairness as he grades the final exams for folks in the GWU program, but that

would be inappropriate of me, and so I'd like to ask another question.

I'm thinking about the interplay between the payment system for physicians in Medicare and Medicaid. Right now, as some of you probably know, physicians under Medicare are slated to get a four or five percent cuts for the next few years, and the argument that's used to say that we should increase funding for them is that you will reduce access for beneficiaries if those cuts go into place. My interchange or my interaction with a number of physician group managers has led me to believe that Medicaid in general pays somewhat less than Medicare to physicians for their services, so my question would be, do you guys have a perception of an access problem for Medicaid beneficiaries as they go to get physician services? And if there is [coughs]—Excuse me—such a problem, do you think that says anything about what should be done with Medicare? And also, do states peg their payment rates for physician services to the Medicare fee schedule, and if nothing is done about the Medicare fee schedule, will states have concurrent cuts in the Medicaid payments that will make access that much more difficult?

DIANE ROWLAND: Well, certainly one of the areas that states have had the most discretion over is provider payment rates. It is undeniable that Medicaid provider payment rates are among the lowest and on average very much lower than the

Medicare rates. Most of the states use a fee schedule. Many have turned large portions of their populations to managed care, where the managed care plans then negotiate the payment rates for physicians. We have a long-standing history of access problems for the Medicaid population because of their inability to find physicians who would take their Medicaid card, but I'm not aware that any inaction on the Medicare payment side will do much to influence where the Medicaid payment rates are, because those really are driven mostly by state policy, and that has been an area where many states have either frozen their physician payment rates, sometimes for more than a decade, and in other cases are looking at reductions in provider payment as one of the ways they're gonna balance their budgets this year and next year.

ALAN WEIL: Let me just add that although we do know of access barriers within Medicaid, if you look at the national data, the general measures of access and utilization for services for low-income Medicaid recipients is as good as and in some instances better than for the equally low–income privately insured. Poor people tend to use fewer healthcare services, so if you compare them to a higher-income population it looks like they're not doing very well, but they're doing as well in the aggregate in Medicaid as they are if they have private coverage, so, as a way of providing access, it does a pretty good job, but not as good perhaps as we would like it

to. The only other thing I would say is because those are sort of aggregates, that can mask some significant pockets of access difficulties. We know particularly, for specialty care, for dental care, there are certain areas of service where Medicaid has long-standing issues of inadequate access.

RODNEY WHITLOCK: And I think that your experience would speak to this, which is that it's much more difficult for a private practice physician to choose not to take Medicare than to choose not to take Medicaid, and I think that will continue to be the case.

ED HOWARD: We've got a question from a congressional office in Minnesota. How do immigration issues, that is to say, undocumented immigrants figure into the Medicaid program itself? Are they usually covered?

ALAN WEIL: Undocumented immigrants are eligible for emergency services only within the Medicaid program. One or two states have applied for, and I'm not completely up to date on receiving waivers to enable them to wrap a little bit around those in a way to reduce the demand on the emergency system, but those emergency services are the only benefits available to that population.

DIANE ROWLAND: There are also restrictions for legal residents who are very recent in terms of a state being able to obtain Medicaid financing for that population, so people within five years of coming into the country, even if legal, are not

covered under the Medicaid program unless the state does so with its own dollars.

RODNEY WHITLOCK: And, I think one thing that is an interesting question, and I know that we dealt with in the last office I worked for, is, there is an issue as to whether or not the state actually asks if you are legally or illegally in the country, and that has created, certainly a source of conflict within the State of Georgia, because within the last couple of years we became aware that the state simply did not ask Medicaid recipients whether or not they were legal or illegal. So in that sense, I think there is a question as to its impact that I think would be worthy of at least consideration and exploration.

ED HOWARD: Yes, Tom?

TOM MILLER: Tom Miller, Joint Economic Committee. That previous question from the floor triggered this one: Senator Rockefeller's not here anymore, but he referred to the efficiency of Medicaid, but we mostly heard about measures of inputs, dollars spent, numbers of people and types of people covered, with no indication of the value of the outcomes produced by Medicaid coverage. Current health policy debates, we know there are various efforts to improve or measure the cost-effectiveness and the value of private health insurance coverage, and we know that in Medicare there's wide variation across regions and providers in terms of that same type of

measure. Do we know very much, if anything, about the value and cost-effectiveness on the outcome side of Medicaid coverage, or do we just kind of hope that any additional dollars are as good as we can do, so as long as there's more spending and someone's being covered, that's the best we can do? I guess the question is not just the access and utilization, because we know that Medicaid pays a lot less for particular services, but what do we know about kind of different ways to perhaps pay more for the things that work well, or to pay them differently, or to organize it differently, that might improve the quality and the value of the coverage being funded in Medicaid? Is there anything out there you can speak to?

ED HOWARD: Good question!

ALAN WEIL: I'll take a start. I mean, I am sure there's a lot that I don't know about the answer to this question, but let me start with a few things. First of all, it is important to keep in mind that a huge portion of the spending in the Medicaid program is for populations where there is sort of no other payer that we can compare them to as a benchmark. With respect to elderly, people with disabilities, the measures that are moving through the private sector in terms of outcome tend to be not targeted to the populations that have as complex health and social needs as the Medicaid populations. It is a little hard to know what our reference

point should be. That's not to absolve Medicaid of any responsibility trying to answer your question, but it is to say that for where most of the dollars go, it's a hard one.

Secondly, certainly the move to managed care for the Moms and Kids population was a combination of an effort to save some money and to improve and organize the delivery system for those folks who often did have access barriers, to move them more into mainstream plans. Some of that happened, some of it didn't, but many states made major efforts to try to measure and hold plans accountable for outcomes in some of the same Hedas [misspelled?] and other kinds of measures that we use in the private sector. There the primary impediment is that the Medicaid population is very volatile. You might have one percent a month turnover in your private enrollment; you have ten percent a month turnover in your Medicaid enrollment. When you're asking questions about people who are on for a year, you find that in Medicaid your number of people who you can track for a few years to see how they're doing ends up being very small relative to the commercial population, which is more stable. So I'm giving you a lot of excuses. I think you're asking the right question, and I think there are many states that are asking that question, and part of some of the challenges that Medicaid faces are inherent to the program. Some of them, I think, can be overcome. I would say Medicaid is a part of the solution and a part of the effort to measure

value. It's not at the forefront with respect to some of the commercial population measures, but I'd say it's ahead of the game when it comes to some of the more complex populations, but it's a challenge that many people are talking about. As I said, there is probably a lot more going on than I can speak to.

DIANE ROWLAND: The one area where I think we are trying to measure some of the value is the performance in school of some of the children who are now covered through Medicaid, and receiving vision, dental and some of the wrap-around services through the EPSDT program. We know those children do better than uninsured children, but how much better and why and what the effect of their health coverage has been on their ability to learn and the function I think is a really important area of looking at and evaluating the impact of the program that has begun in some of the states, but is not very well underway nationally.

ED HOWARD: Bob, could I ask you to—for just a second. I want to get this question in. It's directed to Senator Rockefeller and to Rodney, so I guess you're going to have to answer for both of you [laughter]. And others can chime in if they would like. Given the stopgap piecemeal evolution of Medicaid, is there any appetite for overhauling the whole thing? In other words, if you're gonna spend $300 billion on

care for the poor, elderly and disabled, is this what you would create?

RODNEY WHITLOCK: Let's see.

ED HOWARD: It might be in 102 instead of 101.

RODNEY WHITLOCK: It just occurred to me that the irony of me being asked a dramatic overhaul question from now working at the Senate Finance Committee is right delicious, since, four months ago I sat out there and asked the Senate Finance committee, "You can't possibly do dramatic overhaul!" Obviously I'm not going to speak for Senator Rockefeller. I do think that it is questionable whether or not Medicaid as it is currently structured and its piecemeal evolution is the best that you can do for $300 billion. That said, I don't think I know any better idea right off the top of my head, but I think that is something that hopefully, with the input of distinguished colleagues of the panel, with the cooperation of both Republicans and Democrats, that perhaps we might be able to address, because there are obviously populations out there that are currently underserved. I think if you raise the question of what should a program look like, and what should a federal program be doing, I mean clearly, I think that anybody to go without healthcare coverage is questionable as a matter of public policy, because we pay for it otherwise, and so trying to find ways to approach that is of great utility to us.

DIANE ROWLAND: I think there are two ways to look at that. The first is perhaps it isn't Medicaid that needs the overhaul. Maybe it's our whole healthcare system and our way of financing and paying and assisting people with long-term care, and our lack, again, of universal coverage so that Medicaid has to fill these holes.

But the second thing I'd say is that when you look at Medicaid and you say $300 billion, it sounds like, "Well, and there's lots of room in there to move dollars around." What we've learned from waivers, where there's a budget neutrality requirement, and what we've learned from watching Medicaid over its history is this is not a program that has a lot of excess spending, it just spends a lot on some very expensive populations, and I think it's kind of misleading to think that there's going to be a lot of savings that can be eked out of the existing program that can be applied to filling some of the holes, so I think that tradeoff is one to be very careful of.

ALAN WEIL: If I can get the camera to zoom in on my visual aid here, this question perfectly sets up a report released in January of this year from the National Academy for State Health Policy called Making Medicaid work for the 21st Century. This was the culmination of a year and a half, 25-person collaborative effort to try to come up with recommendations for improving the program. I won't take the rest of the time by describing what's included, although

there's a great simplification of the complex eligibility system, some redesign of the long-term care system. We didn't try to literally take a $300 billion budget and come up with a new Medicaid program, but it does reflect some thinking about ways we could improve the program. If you are interested, you can get copies on our website, **www.nashp.org** for National Academy for State Health Policy. Send me an e-mail, we'll get you a copy.

BOB GRISS: Bob Griss [misspelled?] with the Center on Disability and Health. We've been talking about the Medicaid program as a residual program for a population that basically doesn't have other coverage, but we've also talked about them as having more illnesses and disabilities than the general population, and yet serving only a fragment of that population, like only 20 percent of people with disabilities. Are states and the federal government looking at other solutions to the healthcare delivery system at the federal and state level that might provide other options than monkeying with the unique features of the Medicaid program that could make healthcare delivery more efficient and effective for serving all of the vulnerable populations? In other words, we're focusing mostly in this conversation on what's unique to the Medicaid statute and the way states use their discretion, but when are we going to be looking at other policy options that state have or that the federal government has that could be addressing the needs

of the Medicaid population and other people with those same needs more efficiently and effectively, and equitably?

ED HOWARD: In other words, how much of an appetite is there for a lot of reform.

RODNEY WHITLOCK: It's back to the same question, which is, what kind of reforms could we do if we were not necessarily taking a blank page approach, and maybe not throwing the incredibly long bomb that Diane threw out, which was general health reform, but somewhere betwixt the two, are there things we could be doing, money that we could spend differently? I'll pick out one, and I'm going to disagree albeit mildly with Diane in terms of being able to shift money around. If we found a way to get a third of the elderly currently being served by Medicaid into private dollars in say years six through ten of the next ten years, that's $180 billion, and that's money that certainly could be spent in any number of different ways that might be more efficiently used in the population of which you speak.

ED HOWARD: Rodney, can I ask just a clarification? When you say into private coverage, you mean private coverage paid for by Medicaid or supplementing Medicare, or what?

RODNEY WHITLOCK: Private dollar coverage. I mean, if we can replace public dollars with private dollars to the tune of no more than on third over years six through ten of the ten-year cycle, it's about $180 billion, and that's just a third.

I think that is something that, in terms of people who look at the issue of long-term care coverage for the elderly, that we ought to be thinking in terms of.

ED HOWARD: We've got a few more questions that we can get to. I just want to remind you that there are evaluation forms in your packets for those of you who are in the room. Those of you who are watching or listening, you can go to the website of the Alliance at www.allhealth.org and if you would, fill out an evaluation form that you can either do online or fax back to us. And if you do that, I'll read a couple of questions from the field offices that have come in in the last few minutes. This one's directed to Rodney. You mentioned that the claw-back will phase out, and the way it's phrased here is, "Is that true? [Laughs] But when is it phased out? How does it work? And eventually do the states get out from under completely?

RODNEY WHITLOCK: I'd like to say that I'm supposed to be the expert on claw-back. I'd like to go back and get the formula, get the absolute years. I know it's outside the ten-year window, which was always the universal thing for those of us watching the process, because it allowed the score to go lower than it was, and I can get that to you guys and you can post it.

ED HOWARD: Alan, you mentioned dental coverage. There's a lawsuit, according to this congressional staffer

currently pending in Massachusetts. The state's being sued for a lack of dental Medicaid reimbursement rates—I assume low rates—which have caused dentists to leave the program. Do you or anybody else on the panel foresee the judiciary, state or federal, having a role in forcing lawmakers to revisit federal matching rates, or funding options?

ALAN WEIL: There is language in the Medicaid statute regarding access to services, the reasonableness or comparability—I don't know the exact words—of access to coverage services. States can limit the amount, duration and scope of services, but in creating such limitations, they can't prevent those services from being able to serve their basic functions. These are all nice legal terms of art that I don't carry in my head. There certainly is room. There has been over the past, for instances where issues of payment rates or access have been litigated in federal court. I'm not familiar with the particular lawsuit mentioned in Massachusetts, but it is the case that periodically there are legal actions brought with respect to limited access to services.

ED HOWARD: Okay. Two questions, Alan, triggered by your comment about states not having access to drug information for dual-eligibles. Is this because there isn't an automatic transfer, or is the transfer prohibited? And can this be changed?

ALAN WEIL: Well, as of January 1st, dual-eligibles will receive their prescription drug coverage through the prescription drug plans under the Medicare legislation, and unless someone compels those plans to give the states the information or the federal government through the Medicare agency collects that information and passes it on to the states, there is no way for the states to get it, and maybe over the long haul we can sort of have some information sharing, but in the real time when people may or may not be getting the drugs that they need given their health conditions, without someone requiring that these data change hands from the plans to the states, it just won't happen.

RODNEY WHITLOCK: But Alan, don't you trust the federal government?

ED HOWARD: We'll take that as a rhetorical question and actually, there's another one related that makes a similar inquiry. Assuming that auto-enrollment of dual-eligibles—six million of them in six weeks, is that what you said—does not go smoothly, thousands of Medicaid beneficiaries may have difficulty getting access to prescription drugs on January 2nd, 2006. Are states making provisions to cover medically necessary drugs temporarily if Medicaid beneficiaries are auto-enrolled into plans whose formularies do not cover medications previously received by a given beneficiary? I guess related to that is, are states allowed to make those kinds of provisions?

ALAN WEIL: Well, states can pay for drugs out of their own pocket, but let's be clear: On January 1st, federal matching funds under the Medicaid program will not be available to states to provide prescription drugs to people who are covered by Medicare, and so, it would be 100 percent state dollars, again, without any promise of data to know what the federal government is paying for. States are certainly looking at their options in this instance, including CMS has been involved in talking about giving 60 to 90 day supplies in December so that the transition has a little longer. I would ask my rhetorical question, which is, if the federal government is going to stand up and make a big deal about how there's a new Medicare drug benefit, why on January 1st when that benefit goes into effect would we expect it to be the states through their Medicaid programs to solve the problems created by this new federal program? I mean, it is reasonable to ask what states are doing. It is also reasonable to ask whether or not states should be the ones that have to do it.

DIANE ROWLAND: I think one other thing that's very important to remember here is that the individuals who are being shifted for their prescription drug coverage from Medicaid to Medicare are still going to be on Medicaid for their long-term care and their other wrap-around services, and I think one of the huge concerns here is with the nursing home population and what happens to that group as well, so that the

states are not absolved of all responsibility for this population and part of their concern is if their medications don't get delivered and don't work, they're going to have individuals who will incur other health problems and costs that will ultimately be picked up by the states.

ED HOWARD: Rodney?

RODNEY WHITLOCK: Briefly, and I hear Alan very well, and I think he's making a very valid point, but it's April 4th, and I actually will be surprised if you're still making the same point on October 4th.

ALAN WEIL: And I should say, the questioner said, "Assuming it doesn't go smoothly," and perhaps the assumption is wrong.

ED HOWARD: Okay. We're just about out of time. I want to thank all of you for a very interesting session. We may not have answered all of your questions, but we got to a lot of them. Answer our question, if you will about how we can make these programs better, by filling out your evaluation forms, whether you're here in the room, or listening and watching in congressional offices around the country. I want to thank the Kaiser Family Foundation and the Commission on Medicaid and the Uninsured for their participation and support in this briefing, and I definitely want to ask you to help me thank our panel for what I think was a very helpful and enlightening discussion [applause].

[END RECORDING]

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.