Medicaid 101: A Primer on the Health Insurance Program for Low-Income Americans
Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured
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ED HOWARD, J.D.: Good day. My name's Ed Howard. I'm with the Alliance for Health Reform. And I want to welcome you to this briefing on Medicaid and the basics of that program, extend that on behalf of our chairman, Senator Jay Rockefeller, our co-chair, Senator Susan Collins, and the rest of the board.

Medicaid, you may not know this. You may know this. A lot of people don't. In terms of enrollment, Medicaid is the biggest health insurance program in the country. Over the course of the year it covers many more people than Medicare does. Depending on how you count, maybe as many as 55 million Americans. It's costly. Counting both the federal and state government shares, its price tag is going to be greater than $300 billion dollars this year. And there are two other things you ought to know about Medicaid. First it's enormously important to those millions of low income Americans whom it serves. And secondly, it's incredibly complicated. And it's different in every state.

And that's why we're so pleased to be able to be part of brining you this primer on the Medicaid program. Our partner and our co-sponsor of this briefing, the Kaiser Commission on Medicaid and the Uninsured, is a project of the Kaiser Family Foundation. And Diane Rowland, whom you'll hear from presently, is here from the Commission as one of the country's leading Medicaid experts. I'd like to welcome not

only those of you who are here in the Hart Senate Office Building in Washington, but also those of you in congressional staff offices, state and district offices around the country, and some selected reporters as well. We want you to understand the basics of this important program. You come into contact with people who run it, who have to interact with it, who are beneficiaries of it, who are trying to be beneficiaries of it. And you need to be armed with the information that will help you help them. Thank you for tuning in.

Let me do a couple of logistical tasks before we turn to the program, if I can. In the packets those of you in the room have, you'll find a lot of background information including speaker biographies that are much more generous in time and detail than I will have time to give to our speakers. You'll also find the PowerPoint presentations that are available in your packets and on the screen. And if you're listening on the conference call or tuning in on the webcast, you can find all of those presentations on our Web site, which is allhealth.org a-l-l-h-e-a-l-t-h, which of course brings up the fact that some of you maybe watching live webcast on kaisernetwork.org. You can listen to a conference call if you're computer conks our on you. The number is 1-866-710-0179. The passcode is 264110. There are instructions about all of this, if you didn't copy it all down, on that same Alliance Web site at allhealth.org. If you don't have the

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background materials that we sent to the offices, those are also on the Web site. And you can follow along and read them also at your leisure afterwards. In a couple of days, you'll be able to view a transcript of this program, copies of materials as well at the kaisernetwork.org Web site. You can even download a podcast if you want.

At the appropriate time, once we get through the formal presentations you'll be able to ask questions of our panelists. You have green question cards in the packets that you got when you came in. There are two microphones that you can use to ask your question orally. If you're in a state or district office, you can either send an e-mail with a question if you have it. And that e-mail address is info@allhealth.org, i-n-f-o. And you can send a question by telephone to area code 202-789-2300. And we'll get it relayed to us here. If you missed any of that, as I say you can get it all on our Web site at allhealth.org.

And only one other thing I'd like to say before we move on and that is those of you who have an interest in the Medicare program as well, we're going to be doing a program very much like this Friday afternoon Eastern time. And we invite you to take part in that.

Now, let's get to the program. We have a terrific group of experts for your enlightenment today. They're going to give brief presentations and then answer your questions.

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And let me just make it clear there is no question too simple or too complicated. We really want you to get your questions answered. So don't hold back. I urge you, if you can, to make those questions more factual than policy argument than is normally the case in these sessions because we really want to make sure that once we start arguing we are at least arguing from the same factual base. So let me get started on the more important part of the program.

As I said, we have Diane Rowland with us today. She's our first presenter in her capacity as one of America's foremost authorities on the subject of Medicaid. She's the executive director of the Kaiser Commission on Medicaid and the Uninsured. She's executive vice president of the Kaiser Family Foundation. Diane, if you do not know a bit about her background, has served as a senior professional staff member both here on the Hill and in the Administration. And her task today is to give us a broad overview of this important program. Diane, great to have you with us.

DIANE ROWLAND, SC.D.: Thank you, Ed, and thank you all for coming. Ed said the Medicaid program was complex. I think his instructions for today [laughter] are perhaps more complex than the Medicaid program. And my goal at the beginning of this session is really to just set out the basic framework of the program. And my colleagues on the panel are going to then

delve more into its responsibilities for the different populations it serves.

Medicaid is a complicated program, yes. But it's also an old program that's gone through many changes. It was enacted in 1965 to provide health insurance assistance to low-income individuals receiving cash assistance through then what was the Aid to Families with Dependent Children and the old-age programs for the elderly in the states. In 1972, Congress enacted a federal cash assistance program for the aged, blind, and disabled, SSI or the Supplemental Security Income Program, which broadened Medicaid's coverage for the elderly and disabled along with the implementation of that new cash assistance program.

But the real trend in Medicaid over its history has been in its expansions as a program for providing health coverage, not just to the welfare population but to other low-income families, especially low-income children and pregnant women. Leading in 1997 to the severance of its official welfare link when TANF, the new welfare assistance program, was enacted and then coupled with the enactment in that year of the State Children's Health Insurance Program, which layers coverage for children on top of the Medicaid program.

In terms of the program today, it has many moving parts. And we're going to talk about those as we go through. It provides health insurance coverage to some 27 million

children, 14 million of their parents in low-income families, another 8 million persons with disabilities. So it is our major source of health insurance coverage for the low-income population. But it is also an incredibly important supplement to Medicare for low-income Medicare aged and disabled beneficiaries helping some 19-percent of Medicare's population. And it is our nation's main source of long-term care assistance, covering some nearly 1 million nursing home residents and paying for 41-percent of long-term care. But those roles for the populations it serves are also not reflected in the broader role it plays in our health care system. It is a major source of national health care spending, accounting for 18-percent of our nation's health care bill. And it is the major source of federal financial assistance to states providing 45-percent of all federal funds to the states.

It is a program that varies by states. There are 50 states and the District of Columbia. Each one of them operates a Medicaid program under federal rules and federal guidance. But each shapes and administers its program to suit some of the particular needs of that area. So the structure of this program, unlike Medicare, which you'll hear about later this week, is that it is a joint federal/state program. The federal government puts up some share of matching funds to the states, gives the states guidance as to how they can utilize those funds, and then states design and operate their own programs.

In terms of the basics of the program, Ed talked about the 55 million enrollees. The face of Medicaid is really the face of children. Nearly half of its beneficiaries are children, but the majority of its dollars, 70-percent of its spending, goes for care of the elderly and disabled.

And this slide perhaps is the one that you should remember as you go forward with Medicaid. It really does tell you the story of where the people are versus where the dollars are. And it's another way of looking at is that children are relatively inexpensive as a share of Medicaid because they primarily use the program for preventive health care services and for basic medical care. Whereas the elderly and the disabled use the program for both long-term care and for more intensive medical care then children and incur therefore much higher per capita expenditures.

And I would point out, particularly for the elderly, that those expenditures under Medicaid are on top of whatever Medicare has already paid for their acute care services, really reflective of how expensive it is to care for individuals who are over 65 and have greater medical needs than the young relatively healthy children. People with disabilities fall into a mixed bag, as I'm sure Jeff will talk to you. Some have Medicare. But others are in a waiting period for Medicare or not yet eligible for Medicare, for which Medicaid is the entire health care coverage provider.

When we look at how these services relate in terms of expenditures, you see that about a third, 34-percent of Medicaid spending is on long-term care services and about 60-percent on acute care. And then this small white slice, DSH payments, disproportionate share hospital payments do not go directly to care for individuals as do the acute and long-term care expenditures but instead go to safety net hospitals and other health facilities as a way of helping to provide care not only to the Medicaid population, but to some of the uninsured population.

As I mentioned, within our health care system, Medicaid plays a very important role as a financer of care, 18-percent of overall health care spending. But you can see in the case of nursing homes, 44-percent of their dollars come from the Medicaid program. Prescription drugs, 19-percent though that was just pre the implementation of the Medicare Drug Benefit. So that number will undoubtedly change as some of those expenditures are now covered under the Medicare program.

What we do know about Medicaid is that it is an expensive program because all health care in America is expensive. Most of us know that health care premiums and health insurance require substantial expenditures. The average private health insurance premium today is over $11,000 dollars for a family. But what we do see in Medicaid is that the federal government and the states have a joint financing

partnership. And what this figure shows you is the FMAP, the Federal Medicaid Assistance Percentages, which is the share of Medicaid service spending that the federal government will pick up in each state. It is the matching rate for the states. And you see there that some states, 13, only get one federal dollar for every state dollar they spend. Whereas some six states and the District get over 70-percent of every dollar spent from the federal government. The formula that's used to establish matching rates on an annual basis is based on per capita income in the states and really tries to give a greater share of federal financing to those states that are lower income and that need more assistance in terms of being able to provide their services.

If we look then at how this program shapes up, and what it covers, and who it covers, we see that it covers about 40-percent of the poor, 22-percent of the near poor. It has a much more substantial role for low-income children. But it covers some 19-percent of Medicare beneficiaries, 20-percent of people with severe disabilities, 44-percent of people living with HIV/AIDS, and some 60-percent of nursing home residents. So it has a diverse population with a very different range of healthcare needs. But its benefit package covers that whole scope of needs.

As a health insurer, Medicaid, and Trish Riley's going to give you much more detail on this, provides very different

levels of coverage depending on your family characteristic. Going back to its heritage with welfare and to the fact that welfare assistance was only provided to children and adults with dependent children, Medicaid does not provide matching funds for adults without children under the federal statute unless a state either has a waiver to try and provide that coverage or if that individual, that adult without children, qualifies as an individual with severe disabilities, so therefore qualifies under the disability policy. It does cover parents of children who are eligible for the program. But it only covers those parents at whatever income eligibility level the state sets. Whereas for children, the Congress has gone and set some minimum requirements that children under age six are covered up to 133-percent of poverty and children above that under poverty must also be covered.

So, some minimum standards from the federal government for what constitutes coverage of children. Therefore, as you look at this chart, you see that children are far more likely to have Medicaid coverage or now SCHIP coverage to complement Medicaid then are parents and certainly then are adults without children.

In terms of the role that Medicaid plays, we will be hearing a lot this year about the reauthorization of SCHIP, the State Children's Health Insurance Program. It is a program that layers on top of Medicaid coverage for children. It has a

higher matching rate. So it's more generous to the states in terms of the federal dollars. But it is capped. There is a federal allocation to each state. And once that allocation is hit, the state cannot get additional funds as Medicaid is more open-ended and continues to match all state expenditures. And it tends to cover children above Medicaid, therefore somewhat higher-income children than Medicaid. You see here, however, that for children, Medicaid is still the substantial share of expenditures. It is actually the pink, not the SCHIP program. SCHIP is the yellow. So SCHIP covers about 6.1 million children. And Medicaid covers about 22.3.

And finally, as we will hear more from Jeff, Medicaid remains a critical source of long-term care coverage. It provides 41-percent of overall long-term care expenditures and some 44-percent of nursing home expenditures. Medicare provides for more home- and community-based services, but it's still not a long-term care program. So this is one of the major services that the Medicaid program provides to the Medicare population. So, thank you very much. This is a brief overview. And now we'll probe a little more into some of the depth.

ED HOWARD, J.D.: Very good. Thank you, Diane. Next, we have Trish Riley, who directs the Office of Health Policy and Finance for Maine Governor John Baldacci. She's held nearly every high health care position in Maine, including

directing the Medicaid program. She's responsible for Dirigo Health Reform, which aims to have every Maine resident covered by health insurance by the year 2009. And she's a nationally respected expert on state healthcare issues of all kinds.

And today, as Diane mentioned, she's going to focus on the aspects of Medicaid affecting mothers and children. Trish, thanks for coming. I know it was a chore to avoid being blown down Constitution Avenue, much less the East Coast. So thanks for being here.

TRISH RILEY: Well, I'm a testament to the fact that it is windy on the East Coast today. Well, thank you, Ed. It's nice to be back here with the Alliance. And as Ed pointed out, Kaiser is the preeminent source of information. So I have stolen most of my slides from them. Let first just start and remind us that the focus often when you talk about Medicaid is its cost and whether it's sustainable. But it's important for all of us who work in the policy of Medicaid to keep our eye on the target. And that is it's a critically important program, the only healthcare that so many Americans have. And it's particularly so for families, for mothers and children. It's important for the health of families. It's important for the financial stability of families.

And one need only look at children's access to care to see how that's true. Clearly, children who are uninsured just simply don't get care. Although there are many who will tell

you that no one is truly uninsured because they can always achieve bad debt and charity care and help in hospitals. Look at these numbers. It's still a pretty distressing set of facts about the lack of coverage for people, particularly children, who lack health insurance. Notable here is the fact that children on Medicaid do better than children on private coverage. Medicaid is a program that is particularly designed to cover the real needs of children, primarily through the early periodic screening, detection and treatment program.

Access to care and family financial burden for low-income parents is also critically important. Keep in mind that we're talking here of family for a family of four of about $40,000 dollars. So look at what happens to the financial burden of a family if they don't have coverage. They spend less on basic needs. Medical bills have a major impact on a family. And we're talking about people living at an income of $40,000 dollars. This is significant. Medicaid makes a very big difference on the financial and personal health of families.

Here, you see the percentage of adults 18 to 64 who are uninsured by states. The worrisome piece here is when one looks from 1999 to 2000, the chart on the left to the chart on the right, from 2004 to 2005, you see graphically that we have growing rates of uninsured in the country despite significant

growth in the Medicaid programs. This is obviously a worrisome trend.

And we in Maine just want to pause for a minute to have you just note that Maine's doing better. Here you can see pretty vividly the impact of the state children's health insurance program on reducing the percentage of children without health insurance by poverty level. But worrisome is the fact that we still have 14-percent of kids below 200-percent of poverty without any health coverage at all.

The State Children's Health Insurance Program is critical. But kids live in families. Medicaid eligibility, as Diane notes, is quite complicated. And those of us who are on the Medicaid health side tend not to know very much about the Medicaid eligibility side because of its roots in the welfare program, a separate part of most state governments administrative structures. And it's important to keep in mind that Medicaid simply doesn't cover all low-income families. And when we're talking today, left out of the picture, as Diane noted, are childless adults. Maine is one of, I think, eight states that covers childless adults under 100-percent of poverty. But it is telling that Medicaid, the program designed for low-income Americans, does not cover the poorest among them, childless adults under 100-percent of poverty unless you're a state like Maine with a waiver. And keep in mind that children whose parents have health coverage are more likely to

see a health care provider and have well child visits. It matters to have children and their parents covered.

Here's the median Medicaid SCHIP income eligibility threshold for children, pregnant women, and working parents. And as you can see, children were doing better in large measure thanks to the State Children's Health Insurance Program with the median at 200-percent, pregnant women at 185-percent. But parents, where their eligibility is still linked to TANF, to the welfare roots of Medicaid and not to federal poverty levels, only 65-percent. And where childless adults to show up on this chart, you probably couldn't see it because there's so little coverage for childless adults under 100-percent.

Children's eligibility for Medicaid and SCHIP by income reveals quite significant diversity across the country. And as you can see here, only 17 states are above 200-percent of the federal poverty level, again significant change among the states where states have discretion about where to cover. And you see that more graphically on income eligibility levels here for pregnant women who are applying Medicaid in July 2006. Again, you can see the changes state by state as states make their own decisions based on their values and their own pocketbooks.

I want to spend just a little bit of time talking about the percentage of Medicaid enrollees in working families. Often, one of the myths about people on Medicaid is that they don't work. And here, you see a majority of people on Medicaid

are, in fact, connected to the work force. There is now transitional coverage from six months to 12 months - some states go further, up to 185-percent of the federal poverty level. But what happens when people are on Medicaid and they get another hour's worth of work, or they get a raise, or they get a promotion, and they get another dollar's worth of income? They lose their health coverage completely. Transitional Medicaid helps make that pathway a little easier. But the reality is there is a terrible eligibility cliff in Medicaid that if you work and you get just a little bit more money, you fall off the cliff and have no coverage at all.

So for many people, it's really an appropriate response to not take the extra hours, to not take the pay raise in order to keep one's family covered because, as you'll see in the future slides, it's not often an option, Medicaid or private coverage.

Here's Medicaid eligibility for working parents by income. Again you see significant differences. And only 15 states where eligibility is 100-percent or higher by federal poverty level. These are poor people. Medicaid eligibility for working parents is an area of particular interest. Again, given that 65-percent of people on Medicaid are attached to the workforce, keep in mind that a parent in a family of three, working full time, earns $893 dollars a month at the minimum wage. And here, you see pretty significantly what happens to

low-income parents in the workforce. In 24 states, those minimum wage families earning $893 dollars a month don't qualify for Medicaid. It really raises the policy question of, whose responsibility are these in a country like ours where employer-based coverage is how we get health care? Where is the line between Medicaid eligibility, Medicaid responsibility, and employer coverage and employer responsibility?

Health insurance offer rates by firm characteristics. Now most people who are offered coverage take it up. And you look at this chart and you'll see the notable pieces of the slide here are in small firms, under 200 workers, where most uninsured work, only 60-percent are offered coverage. In lower-wage firms, only 42-percent are offered coverage. And this is where you will find disproportionate numbers of the uninsured. So here, you see lower rates of offered for those people and small firms less likely to offer. But the important thing to remember is many, many Medicaid members, beneficiaries work part time, in part not to exceed the eligibility cliff and a fall off the cliff, and in part because that's what they're able and offered.

So here you see, I think, a Maine statistic that I think you would find consistent across the country. And while many companies offer coverage to full-time workers, few offer them to part-time workers. So if you are a working, low-wage

parent, the likelihood of you being offered health coverage and the likelihood of your ability to pay for it is slim, indeed.

There are premium assistance programs available in which Medicaid pays for the employee's share of health coverage. But they're very difficult to administer by the states. And few have had significant success with them, Rhode Island being the exception. You have to determine which program's eligible. You have to determine wraparounds for services. There's issues of cost sharing that are significant. So there are real questions, I think, about whether premium assistance makes sense particularly given the fact that as the earlier slides show, few low-wage, Medicaid-eligible or potentially eligible people are offered coverage because they're either in low-wage, small firms or they're working part time. So there clearly need to be new strategies to address the nexus between employer coverage and Medicaid.

And I want to close in just a blatant attempt to tell you that we feel pretty good about what we're doing in Maine. This paid political advertising, I guess. But the fact is, on this slide, which is probably a little difficult to see the uninsured rate for low-income, non-elderly by state, Maine leads the nation in covering people below 200-percent of the federal poverty level. And we do that through Medicaid. The importance of the program in a state like ours that's invested in covering the uninsured is unequivocal. So I'm sure you'll

hear much more from Jeff about the further details of where the spending is.

ED HOWARD, J.D.: Great. Thank you so much, Trish. And as Trish indicated, Jeff Crowley is our final speaker. Jeff is a senior research scholar at Georgetown University's health policy institute where he concentrates on the impact of Medicare and Medicaid policy issues and questions and their impact on people with disabilities and chronic conditions. That's what we've asked him to focus on today, how Medicaid serves older people and those with disabilities. And I should note that he's one of the countries top experts on HIV/AIDS, served as the deputy executive director of the National Association of People with AIDS. Jeff, thanks for being with us and we'll look forward to your remarks.

JEFFERY CROWLEY: Great. Thank you, Ed, and good afternoon. As you can probably tell from listening to both Diane and Trish, Medicaid as has been said is so complicated. It's like peeling an onion. And I could peel seven layers and your eyes would glaze over. But I'm going to try really hard to maybe just do one or two and keep it very simple.

So the first point I'd like to make when talking about seniors and people with disabilities is that the program is really essential. It covers about 6 million seniors, people age 65 and older and about 8 million non-elderly people with disabilities. And I think the other thing that we need to

pause and think about is we're not just talking about a source of payment to provide sort of basic healthcare, doctors and hospital services. If you look at this slide and look at the diversity of people covered by the program and the diverse range of needs, it's really challenging and remarkable that Medicaid does this. It covers children and adults with disabilities, people with all sorts of disabilities, physical disabilities, mental illness, intellectual disabilities, Alzheimer's disease, you name it. And all of these conditions often cases have very unique needs.

So when we talk about getting in the program, it works slightly differently for seniors and people with disabilities. Seniors, people age 65 and older, can be eligible for Medicaid if they have low incomes and limited resources. For people under age 65 to qualify on the basis of disability, they have to have low income and limited resources, but they also have to demonstrate that they have a disability. So the first step in doing that is for them to be determined to have a disability by the Social Security Administration. Now, I should say that in this country we have about 54 million people with disabilities, roughly speaking. And as I told you, only about 8 million non-elderly people with disabilities are covered by Medicaid. And that's a sign that when we're talking about giving income assistance through the Social Security programs or providing health coverage through Medicaid and Medicare, we're not

covering all people with disabilities in this country. We're really talking about people that meet a fairly strict standard for having a severe disability and a permanent or long lasting disability.

Now in thinking about the process for being determined to be disabled, there's a couple observations I'd like to make. Again it's a strict standard. The application process can be difficult to navigate. And many people find that it's more cumbersome then they can do on their own. So they often find that they need to either find a lawyer or a benefits counselor to help them. And just as one example, for people with mental illness, you often hear about people that don't qualify for Medicaid until they've had a series or hospitalizations or sometimes incarcerations because they needed a record of disability.

And then the last thing I would say about the process is, for some conditions, early access to care can be difficult. So if we think about conditions such as multiple sclerosis, Parkinson's disease, HIV/AIDS, once people with these conditions are identified, I think our goal is to get them early access to treatment. But because of the progressive nature of these conditions, many don't meet the Medicaid standard for disability until their condition is fairly advanced. So in the case of people with HIV/AIDS, they wouldn't qualify on the basis of disability until they have an

AIDS diagnosis. So there's many years when they're ineligible as disabled.

Now, turning to figure four, I'd like to point out that for both seniors and people with disabilities SSI is a major pathway to getting into Medicaid. There's a complex array of public programs, a Social Security program. But what SSI is or supplemental security income, it's a Social Security program that guarantees both seniors and people with disabilities income support up to 74-percent of the poverty level. So in 2007, that means that the program pays $623 dollars in monthly income for individuals to meet their basic living expenses. Generally, in most states, individuals that receive SSI are automatically eligible for Medicaid. Now, low-income people can receive assistance from overlapping programs.

So, for example, a senior could receive Social Security. A working age person with a disability could receive SSDI or Social Security Disability Insurance. But those income support programs are based on past contributions to Social Security. So it's possible that if they are a low-wage earner, those payments would be low. And SSI can supplement those programs to ensure that everybody has an income up to again that 74-percent of poverty. It's also possible for individuals to receive both Medicare and Medicare, as Diane mentioned. And the dual-eligibles are a particular population that we want to focus on in Medicaid.

So turning to figure five, an important observation to make is that Medicaid does play an important role in meeting some of the health and long-term services needs of low-income Medicare beneficiaries. If you look this slide, you can see that dual eligibles account for only 14-percent of Medicaid enrollment. But they account for roughly 42-percent of the program's spending, often covering services not covered by Medicare. So if you look at the pie on the right side of this figure, you can see that the biggest portion of spending is for long-term services and support. But it also covers other acute care against services that either Medicare doesn't cover or covers in a limited fashion. Because this slide is from 2003, before we had the Medicare Part D program, you see some spending for prescription drugs. Medicaid also pays for Medicare premiums, whether it's cost sharing for Part A service in Medicare or the Part B premium.

Turning to figure six, a point I'd like to make about dual-eligibles is when we compare dual-eligibles to other Medicare beneficiaries, it's important to note that there are factors about them that make them more likely to need assistance from Medicaid. What this shows that they are significantly more likely to report being in fair or poor health. They are significantly more likely to report having an income below of $10,000 dollars. They're more likely to reside in a long-term care facility such as a nursing home. And on

key health indicators, they're more likely to report having diabetes, having had a stroke, or having Alzheimer's disease.

Next, I'd like to turn to another issue and that is focusing on high-cost populations. It's probably been true for the history of the Medicaid program but certainly as long as I've been involved with the program and the for the last decade or so, there's just been an ever-increasing focus on controlling spending, making sure the program operates as efficiently as possible. And I think in that effort to do that, I think some policymakers are recognizing that maybe what we need to do is increase our focus on the very small portion of the Medicaid population that's responsible for a very large portion of the expenses.

What this figure shows is that 3.6-percent of Medicaid enrollees are responsible for nearly half of Medicaid spending. So as a policy response, if we're trying to save money, maybe we need to look for strategies to better coordinate services for these individuals or coordinate their care.

Another issue about looking at high-cost populations is there's lots of different ways you could cut it. I should also step back and say that these data are presented from the Kaiser Commission on Medicaid and been assured by work done by researchers at the Urban Institute. And for their purposes here, we define high cost as people having annual Medicaid expenditures of greater than $25,000 dollars. So what this

figure eight shows is that if we look at per capita spending for a long-term services users versus people that don't use long term services in Medicaid, long-term service use seems to be a fairly good predictor of who's going to be high cost. Average cost here, seniors that use long time services about $31,000 dollars a year, for people with disabilities more than $46,000 dollars a year, for others, which is probability parents that need some long-term services, $17,000 dollars a year. All of these numbers are significantly higher than the roughly $2,300 dollars a year for people in Medicaid that don't use long-term services.

The next point I'd like to make on figure nine is that an important role and, essentially, a unique role of Medicaid compared to other programs, is they way that it integrates acute care and long-term services. Now, acute care services are often what think of as primary Medicare, physician services, hospital care, prescription drugs, laboratory tests. Now, long-term services or long-term care refer to the services and supports that people need when their ability to care for themselves has been reduced by a chronic illness or disability. Sometimes what these are referred to as activities of daily living or instrumental activities of daily living and cover assistance with things like dressing, bathing, preparing meals, managing a home, managing finances. And when we look at this, Medicaid pays for 42-percent of long-term services spending in

the United States. And this is compared to 20-percent from Medicare.

Now Medicare, much of that spending is really for short-term rehabilitation. Someone may be injured themselves so they need some skilled nursing while they recover. Medicare does not pay for people that need long-term services on a long-term ongoing basis. And then compared to only 9-percent for private insurance.

Now, when we look at trends and long-term services spending, I think we can note a couple things. On figure 10, we can see that looking at the period form 1991 to 2005, long-term services spending has nearly tripled. We can also see from this chart that roughly two-thirds or a significant majority of spending is for institutional care. But we can also see a clear trend that over recent years, virtually all the growth in spending on long-term services has been to provide community-based services.

Now, from a policy perspective, I'm now turning to figure 11. I think there's a consensus that we really need to reorient our long-term services system to provide more community-based services and minimize the extent to which we provide institutional care. From the perspective of people that need these services, people with disabilities, many people are really demanding the right to live in their own homes and receive the services and supports they need. But from a policy

perspective, many policymakers really believe that community-based services are cost effective. So there's lots of reasons why we want to do this. What this chart shows is that some states have come much further than the others. About 10 states already spend more than half of their long-term services spending in the community. I'd like to highlight in particular, I think, Oregon leads the nation in spending about three-fourths of its long-term services spending in the community. But then some states are really lagging behind. Two states are Mississippi and the District of Columbia, spend less than 20-percent of their long-term services spending in the community.

Now in closing, I would just like to emphasis that Medicaid plays a very unique and important role in meeting the health and long-term services needs of a diverse range of people with disabilities and seniors. It assists people with extensive needs at all stages of life. Recently in the news we've heard a lot about people with traumatic brain injuries, service related injuries returning from Iraq. But we have those injuries here domestically. And for people that have traumatic brain injuries, they'll injure their spinal cords in a car accident, you know, those can be catastrophic. And often people may even find themselves uninsured or underinsured and they often turn to Medicaid. It's really the only thing that's available to meet their extensive needs. Medicaid also plays

an essential public role. And there's some cases that there's uniquely public functions that Medicaid fills such as providing services to children in foster care. As I stated earlier, it plays a really unique role in integrating acute care and long-term services, whereas I mentioned Medicare and private insurance they really are focused on acute care and they don't really provide very many long-term services. Medicaid's role in integrating these services is unique. And then, finally, it's just a critical safety net that private insurance and Medicare while important are not necessarily designed to meet the very extensive needs of some high-cost individuals. And with that, I'll stop and thank you.

ED HOWARD, J.D.: Thank you, Jeff. Okay. That is the whirlwind tour of the Medicaid program. And I daresay the panelists themselves, though I will say they did incredibly good jobs in each of the areas, left a few things that they didn't cover adequately to answer all of your questions. So we're going to give you a chance now to go to the microphones here, fill our the green question cards and hold them up, and keeping Diane's observation in mind, let me see if I can also review for those of you listening or watching the webcast how you can submit a questions without confusing you completely. There are two ways. You can either call 202-789-2300 or you can send an e-mail to info@allhealth.org a-l-l-h-e-a-l-t-h.org. So

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we welcome your questions and we welcome your comments if you have them.

Let me start with one that came up from the audience right at the beginning of the session. And it's directed to Diane and it asks that you talk a bit more about Medicaid and the State Children's Health Insurance Program. Do they work together usefully? And the questioner raises the possibility that maybe we don't need both those programs that we could get by with one or the other. Particularly timely, given Congress' consideration of the SCHIP program for reauthorization this year.

DIANE ROWLAND, SC.D.: Well, as I said, the Medicaid program was set up originally to provide health insurance coverage to children receiving welfare assistance. And then states were, in the early days in 1967, given the option of broadening that coverage to other children who were low-income but not receiving welfare assistance. So Medicaid has a long history as the source or health insurance coverage for low-income children. It operates as an entitlement program. Anyone who meets its income and, in some cases, asset test but that has been eliminated by most states for children, would be covered by the Medicaid program. Legislation through the 1990s broadened coverage, first giving states the option to go to higher income levels for children and pregnant women and then, as I mentioned, putting in the mandated coverage for all

children under the poverty level and low-income young children under age six and pregnant women under 133-percent of poverty.

So those are the minimums that every state must meet under their Medicaid program and, as I showed you in one of the slide, they get their Medicaid matching rate for those services. SCHIP was enacted in 1997 with two major differences from Medicaid. One is that is was to cover children not eligible for Medicaid above the Medicaid income levels. And two, the program had a higher matching rate. But the federal dollars for the program were capped. So it was not an entitlement. It was a capped program that allowed states to spend up to their allocation. And then after that they were required to use all state dollars. But they did get a higher federal matching rate. It was an option for states to implement the program. And all states did do so. What I think is important is that they can be totally merged together. And some states have done that. That was one of the options the legislation allowed. Or they can be operated as separate programs. The evidence today is that both programs work together fairly effectively. That the SCHIP program with its goal of enrolling more uninsured children helped to bring some simplifications in terms of the enrollment process and procedures for Medicaid. And they do have, in many states, obviously, a common name and a common enrollment where the matching funds are sorted out by the administrators. But for a

family, it's a seamless transition between Medicaid and SCHIP. In other states, they're separate programs and differences. So it could be made more seamless and more able to work together.

But the current evidence is that the two programs at least have done, as Trish's slide showed you, a really remarkable job in reducing the number of uninsured children and in keeping their rate from growing. Most of the growth in our uninsured has been among adults, not among children, largely due to the success of the two programs. But Trish might want to comment on how it works in Maine.

TRISH RILEY: Well, in Maine, we have combined the two programs fairly effectively to serve all children up to 200-percent of poverty. But I would, for the question of do we need both, I think one of the most telling things in the reauthorization debate in deliberations is the fact that states like ours have hit the wall. There's a difference between an entitlement program where you have eligible children and resources to meet them as long as the state has its match. In the CHIP program, as a capped program, you reach your cap. And no matter what state match you have, you simply can't get more federal funds. We're in a $6 million-dollar deficit to try to meet our needs today.

So I think that it really reminds you while the CHIP program with its higher match and its flexibility and its opportunities to be very creative have led to some terrific

advances, the fact is you hit the wall in a program that's not an entitlement.

ED HOWARD, J.D.: Okay, we got two questions involving waivers, one general, one specific. And the first one anyway is directed to Jeff asking if you, Jeff, might explain a little bit more about the waiver concept and whether the waivers differ by state. And the specific question has to do with whether waivers are available to allow states to cover persons with disabilities with preventative care. For example, providing treatment for individuals with HIV, but not a full diagnosis of AIDS, which you mentioned in your remarks.

JEFFERY CROWLEY: Great. Thank you. Well, again, now I get to spend 10 minutes trying to explain how waivers work. I should say a couple things briefly about waivers, that waivers operate under the Medicaid law under different authority. So there's different types of waivers that allow different things to be waived. But fundamentally what waivers are is federal permission for a state to operate their Medicaid program not complying with certain specific Medicaid rules. So sometimes states get a waiver to provide targeted services to people with disabilities. And what they're waivering is the requirement that services must be comparable among all beneficiaries. So there are some waivers called 115 waivers that have done statewide reforms that cover all populations.

Arizona is an example of a waiver program that operates – their whole state Medicaid program operates under a waiver.

But in the context of disabilities, there are what are called 1915(c) waivers or HCBS waivers, which are specific waivers that allow states to provide community-based services to people that if these waivers weren't available, they would qualify for nursing home care.

So the question about, can states get waivers to cover preventative services as with HIV, that is something that generate a lot of interest maybe about 10 years or so ago. And a few states were approved to have waivers to expand to people with HIV who aren't yet disabled by AIDS. Now, some of the states approved never were able to implement their waiver because they weren't able to meet the so-called budget neutrality requirement. Sort of a core principle of waivers is that in operating a waiver program, you're not going to increase your cost above what the federal government would pay just for its regular Medicaid program. So some states have used, Massachusetts operates a waiver where they have extended Medicaid to people with HIV who aren't yet disabled by AIDS. But other states try to do it and were challenged by the budget neutrality requirements.

ED HOWARD, J.D.: Okay. Somebody doesn't want to let go with the question of Medicaid and SCHIP. Doesn't combining the two, the questioner writes, make sense to decrease

administrative costs? And those of you who talked about that may want to try that again.

And let me throw in one other complication. And I should give Trish the chance to reiterate her linking of the question of a capped program versus an entitlement as a part of this. But what sense does it make to provide a higher percentage match to states for covering higher-income people, as opposed to the very low-income people who are in the Medicaid program? Okay?

TRISH RILEY: Well, I'm from a state so I can say there's a lot about the Medicaid program that doesn't make a lot of sense [laughter], like notably that you have to get a waiver to cover the poorest. And you get higher match rates to cover kids at 200-percent. But then you can't cover their parents who are still then about 65. So there's all kinds of inconsistencies in the laws. So think to that there are political reasons obviously for SCHIP's popularity. It's a different kind of program. It's not an entitlement program. It isn't Medicaid. And Medicaid comes with all the baggage of a program that has to balance many, many competing interests. But I think the notion of a combined program when we're thinking about low-income people.

And in Maine, our goal has been to use Medicaid and CHIP to cover everybody up to 200-percent of poverty as much as we can. And we've largely achieved that goal. So I think

whenever you think of simplification of programs, there are obvious reasons that one might think about combining the two programs. The challenge would be what do you do with the higher match rate? What do you do with the political popularity of the State Children's Health Insurance Program?

DIANE ROWLAND, SC.D.: There are also clearly two issues here. One is whether you combine or make the programs one at the federal level or, two, whether you let the states combine them at their own will. And the current structure allows the states to combine Medicaid and SCHIP together so that they can run a single program and have those reduced administrative costs, which was the question here. But it still does have the cap on the federal spending allotment for the SCHIP program. So it does create a budgeting issue at the state level that would not be the case if everything were merged into an open-ended entitlement like the Medicaid program.

ED HOWARD, J.D.: I've got a quick factual question here. Does Medicaid cover individuals who are incarcerated and have disabilities such as mental health problems or HIV/AIDS? Jeff?

JEFFERY CROWLEY: No. Medicaid doesn't cover people who are incarcerated. If you're incarcerated in a federal prison, the Federal Bureau of Prisons is responsible for your health ,care.

ED HOWARD, J.D.: Okay.

TRISH RILEY: But states cannot receive matching funds through Medicaid for the coverage of their prison population.

ED HOWARD, J.D.: Good point. Jeff, this probably ought to go initially to you also, questioner wonders, if community-based services spending has increased, then why has institutional care spending not decreased? Are we covering more disabled or are some of the for-profit care facilities enjoying a windfall?

JEFFERY CROWLEY: Those are hard questions to answer. I think that there's been both efforts to increase need but also, costs are going up. I think what we're seeing is a trend where there is a slow rebalancing. So we're making incremental new investments in community based care. But the services we're providing in institutional settings are themselves quite costly. And we haven't seen an effort where we're seeing great decreases of the number of people in institutions. We're really just talking about providing more community based services. I would also say there's a huge unmet need. When we look at the HCBS waiver program, for example –

ED HOWARD, J.D.: I'm sorry. Jeff, what's HCBS?

JEFFERY CROWLEY: That's the Home- and Community-Based Services waiver program. I mentioned earlier a waiver for providing community based services to people with disabilities. In that program across the states, there are about 200,000 people that are eligible for services but are on waiting lists

just because the waivers don't cover all the people that need services in those states.

TRISH RILEY: And I would point out in a state like ours that the growth of chronic illness is real in this country. It relates to the earlier question about prevention and my worry about parents. If we're not covering parents and we're not diagnosing and treating diabetes and other chronic diseases early, they become very serious problems later in life. So we have an aging population. We have chronic illnesses that are growing and not treated and, in our state, a significant growth in diagnosed mental illness, particularly among children, which certainly drive budgets.

ED HOWARD, J.D.: Okay. Here's another question that's been submitted. How effective has Medicaid managed care been versus non-managed care? And have states increased the number of managed care Medicaid programs and the numbers of people under those programs? Diane?

DIANE ROWLAND, SC.D.: Well, today, if you look at the Medicaid program and its coverage of low-income families, more than its coverage of the elderly and disabled you will see that the majority of low-income families are in managed care programs. The original managed care programs were implemented at the state level with two purposes. One was to try and get a handle on costs and to reduce costs or to at least make them more predictable, especially be moving to capitated payments.

And the second was that Medicaid has historically paid physicians very low rates and had very poor participation for physician care for the Medicaid population. So the other goal was to secure a set of network providers that would actually provide care to the Medicaid population.

I think if you look across the country, you can see that there has been mixed success both with managed care as a way of saving money but it has, in many states, made care more predictable. I think some states have implemented programs that have really secured a better primary care network than in other states. So as I said at the beginning, it's 51 experiences, 50 states and the District of Columbia, almost all have embraced managed care but some have gone to a more capitated model. Others have gone to more of a primary care case management. So it's been different strokes for different folks. And it's been differently effective. Where they're moving now is more toward managed care for the people with disabilities, which is perhaps an even greater challenge than for children and some of their parents because, as Jeff has pointed out, these individuals have a much wider range of health care needs. But there's also some evidence that coordinating their care, especially for those with very high costs, could lead to better outcomes and to more effective care delivery.

ED HOWARD, J.D.: Okay. Someone would like someone on the panel to explain the Medicaid spend-down concept involving the spouse of a disabled person also in the spend-down. And discussion would be appreciated about the amount, whether it's too high, too low.

JEFFERY CROWLEY: Well, the spend-down concept is largely an issue for what's called the medically needy program. And this is a way that people can become eligible for Medicaid if they fit into one of the eligibility categories, like they're a senior or a person with disability. But they start out with income in excess of Medicaid standards. So what they can do is they can incur medical expenses then subtract it from their income. And then as long as it's below a state-set medically needy income limit, they can become eligible for Medicaid.

Historically, this was really a way to get people that had somewhat higher income into Medicaid who needed nursing home care. But now we're seeing that it's being used for a whole variety of purposes. And certainly for seniors and people with disabilities, it's a major Medicaid eligibility category.

There are some challenges with it. I looked at this issue a few years ago for the Kaiser Medicaid Commission. And at the time, the median Medicaid medically needy income limit was about 50- or 55-percent of the poverty level. So that

meant that people had to spend down to 50-percent of poverty. And all that remained that had to cover all their expenses. I know in a couple states they had to spend down to $100 dollars or $107 dollars of monthly income, by which they were supposed to use that $100 dollars to pay for food, rent and all their other expenses. So there are challenges because not every state has a medically needy program. And then the spend-down levels are quite low.

ED HOWARD, J.D.: Okay. There are 9 million uninsured children, the questioner writes. But 6 million of them are already eligible for Medicaid or SCHIP. What are the two or three best ways to get kids enrolled? Aren't there some states that have a great track record that we could emulate? How about Maine [laughter]?

DIANE ROWLAND, SC.D.: Well, increasing your eligibility always helps. And I think there's significant evidence in the research and in our experience that when you cover parents, kids also get covered as well. That when kids are left alone without parent coverage, parents are less likely to participate in programs and to get them access to care. I think some of the things that other states have done that have been particularly effective is streamlining applications, streamlining the eligibility process, simplified one-page kind of eligibilities, and significant outreach to the schools. And the states that have been really creative about the first day

of school, the kids come home with the application for that's a one-pager to get into the programs. And I think those kinds of things, there's significant work that's been done that you can get at the Kaiser Web site that can show you the strategies that are very effective.

DIANE ROWLAND, SC.D.: I think certainly simplifying the enrollment process and remembering that when you sign up for health insurance on the job it's kind of a one step process. But when you're asking to sign up for Medicaid or SCHIP, you're asking people to go to a different source to sign up. And so to make that as seamless as possible, to make face-to-face interviews and documentation less burdensome are clearly strategies that many states have found effective.

And it goes to another question that we got, which was the new documentation requirements enacted by the DRA, the Deficit Reduction Act, and the possible implications on Medicaid eligibility and enrollment. And this is the requirement that citizens prove their citizenship as a condition of Medicaid eligibility, either at the determination process or at the original enrollment. And we have heard from some of the states that this has created an impediment to their ability to try and reach some of the low-income children who are eligible but not enrolled because having a parent have to produce birth certificates, having to produce lots of paper to document each of their children's eligibility for citizenship

purposes is a new documentation requirement. It actually goes against the trend towards simplifying it, doing it online, and doing post-verification. So that this is obviously an issue of great concern to those who are trying to find those 6 million eligible but not enrolled and bring them in.

And is one that I think will be looked at again at the state level in terms of, how can that be simpler? How can they use administrative data to reduce the burden on families and to promote broader enrollment in the program?

ED HOWARD, J.D.: Thank you, Diane. Here's a question that I believe came from our network of folks listening and watching in state and district congressional offices. It's the office of Congressman Steve Chabot from Ohio. The questioner writes, because hospital care is extremely costly, will Medicaid be expanding its home- and community-based services program to reduce state expenses? I've been involved in adult cases where both Medicare and Medicaid claim the constituent is covered by the other. How can this problem be resolved for HCBS participants? And what can I do for my constituents?

JEFFERY CROWLEY: That's a tricky question. I'm not sure how to answer it. The first question is when we talk about expanding home-, community-based services, we're really talking about long-term services as opposed to institutional like nursing home care or ICF/MR. Individuals that receive home community-based services, whether it's through a waiver or

through state plan services, are also eligible for hospital services. I think the questioner raises and important issue that for dual-eligibles there is a question, people can get stuck about who's responsible. Generally, Medicare is the primary payer and Medicaid's job is to supplement for payments not covered by Medicaid. But I don't know that I know how to answer that for how we give you any great advice for how we resolve those issues. They do certainly come up.

ED HOWARD, J.D.: Trish.

TRISH RILEY: There were initiatives, back in the Dark Ages, to try to get waivers for states to do both Medicare and Medicaid. And I think the only one that was ever granted was Minnesota. But I don't know much more about what happened to try to integrate care and to have one care manager who is able to leverage both Medicare and Medicaid.

ED HOWARD, J.D.: And if we have anybody in the audience who is involved in the administration of the programs at the federal level and would like to address any of these questions, they should feel free to repair to microphones and add their expertise.

Question about dual-eligibles that is, people enrolled both in Medicare and Medicaid, who among them are in Medicare besides elderly and people with end-stage renal disease? Are there other sorts of health conditions that qualify people?

JEFFERY CROWLEY: So who's in Medicare other than seniors and end-stage renal disease?

ED HOWARD, J.D.: And end-stage renal disease.

JEFFERY CROWLEY: Well, you can receive Medicare if you're a senior, age 65 or older, or if you're a working-age person that becomes disabled. So any of us in this room or in the audience, if you've been working and paying into Social Security, when you develop a disability, as I mentioned at the very beginning, Social Security determines that you have a disability. I then went to SSI. But another pathway is if you paid in through your working contributions, you can receive Medicare.

Now first, you have to be determined to have a disability. You wait five months so they can be sure that it's a permanent or long-lasting disability. Then you start getting SSDI payments. Then when you first get your SSDI payment after 24 months, you can start getting Medicare. So non-elderly people with disabilities can get to Medicare. In addition to end-stage renal disease, there's also special treatment though for people with amyotrophic lateral sclerosis or Lou Gehrig's disease can also get Medicare.

ED HOWARD, J.D.: Let me just take a second to remind you there are in your packets, whether you are here or in a district office somewhere, blue evaluation forms that we would

ask you to fill out before you leave so that we can improve these programs for your better good.

Here's a question about the other side of the equation in some ways - that is to say, payments to providers. What is the current trend in provider participation in Medicaid programs, both traditional and managed care coverage? And if there is a problem, have any states considered holding the privilege of holding licensure to practice, I can't read the word, but basically hostage to a requirement of providing care to Medicaid participants?

DIANE ROWLAND, SC.D.: Well, currently, the states have had discretion over how they set their payment rates. There are not any real requirements on what those levels would be except that they can't exceed Medicare payment levels, which is not really a problem in most states. What they have done is obviously to try and have the managed care plans when they take over, set their own payment rates to providers so that those obviously vary now widely according to how the managed care plans implement their payment schedules. There is evidence that when economic times are better, states recognize both on the institutional side and on the community-based provider side that their payment rates may not be sufficient to attract reasonable participation in the program so that we do see increases in nursing home payments, increases in physician payment levels, often implemented during times when the states

are not under great fiscal stress. However, we also see in the annual budget survey that we do that the first place states turn when they have an economic downturn and they have fewer revenues to support their share of the program cost, more people applying for program coverage, and they need to save money to meet their budget targets because all states have to balance their budgets. They do then start to reduce or freeze provider payments.

So I would say the gauge of what states pay providers is very much related to how well their own economy is doing. And there are restorations often of provider fee levels during better economic times recognizing that access to care is compromised when fewer physicians participate. Over time, we've seen not a low level of participation of the provider community in the Medicaid program, but not any dramatic dropoffs in coverage. It's just a persistent problem.

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

JEFFERY CROWLEY: No, I don't.

ED HOWARD, J.D.: Trish Riley mentioned EPSDT and even told us what it stood for. You want to explain EPSDT a bit more, in particular what types of services are covered in conjunction with that benefit? Are services that are otherwise considered optional mandatory under EPSDT? And do states have discretion in determining what services are covered?

TRISH RILEY: Next question [laughter]. EPSDT basically provides for any medically necessary service that a physician determines is appropriate for a child. As a result, children under the Medicaid program have been able to access a wide array of services, particularly kids with mental illnesses and special needs have been able to get a wide array of services that are not always purely medical as one would think of them. They're often supportive services. And they're the services that one can provide is virtually, I think it's fair to say, endless as long as it's medically necessary and a physician determines it to be so. So it provides considerable flexibility that has been pushed back. And you've probably heard some feel that that's an open door in the program that allows for extensive expenditures that states can't control. And I think the trigger here is that it must be medically necessary. And it is up to the states to make that determination about what medical necessity is.

ED HOWARD, J.D.: Okay. I want to compliment you for the volume of questions that you have provided us to chew on. This one asks the panel to discuss the use of assisted living facilities and assisted living services by Medicaid programs. Jeff, you want to take the first crack at that?

JEFFERY CROWLEY: I'm not sure I can answer that. Well, I know that there are some restrictions on Medicaid funding for assisted living.

ED HOWARD, J.D.: Okay. Trish?

TRISH RILEY: The challenge of assisted living, and we do a great deal of it in Maine, is the challenge of when one pays for room and board. That you can pay for room and board in a nursing home but not in a community-based facility. So the issue is you can buy a package of services, but you can't always help the low-income person provide for the housing cost. And states have done a variety of fairly creative ventures to try to maximize the use of assisted living. And I would refer you to the work of Robert Molucka [misspelled?] at the National Academy for State Health Policy, who really is, I think, the nation's expert on assisted living, which is just www.nashp, n-a-s-h-p.org.

ED HOWARD, J.D.: Okay. Good. Here we go. How does SSI correlate with Medicare for non-elderly disabled who are currently covered by employer group health plans when Medicare becomes available after that two-year waiting period Jeff was describing, after the decision to either pay a Medicare premium they don't need or suffer a Medicare penalty later when they turn 65? Did I –

JEFFERY CROWLEY: I'm not sure I get the question.

ED HOWARD, J.D.: Diane, I'm not sure I am reading this correctly. So let me try again, or why don't you try again [laughter]?

DIANE ROWLAND, SC.D.: I think the question here is that if someone is working and covered by an employer group plan and then becomes eligible for Medicare after the two-year waiting period, are they subject to a penalty if they don't sign up for Medicare and choose to keep their employer-based coverage or not? But the likelihood is that if they're severely disabled, they're no longer working.

JEFFERY CROWLEY: That's correct. And I don't even know how we answer that. There are so many complications because Medicare, you essentially have to take it once you become eligible. And if you have Medicare and want to return to work, there are programs you can engage in to keep your Medicare and continue working. But I don't know what would happen if you didn't take it. I think that's a very rare scenario, though. I think what you more likely find are people that are desperate to get Medicare coverage and they might contemplate working. But they will do anything to make sure that nothing involved with their work jeopardizes their ongoing Medicare coverage.

DIANE ROWLAND, SC.D.: And many of the people in that waiting period for Medicare would be receiving if they're low-income Medicaid assistance. So one of Medicaid's roles is to fill in that waiting period gap before Medicare eligibility is established. And then once they get onto Medicare, they still may not have the full range of benefits that they need from the

Medicare program. So if they are low-income, they may continue with Medicaid as then a wrap around as a dual eligible to provide supplemental benefits, especially the long-term care benefits that Medicare doesn't cover.

ED HOWARD, J.D.: Another question involving dual-eligible and it's not surprising, this is a murky area and one that consumes a great deal of attention and money from both programs. Any comments from the panel regarding the fact, and I'd also like to know whether the panel shares the assertion that it is a fact, that many state Medicaid plans will only cover Medicare's share of costs for those dual-eligibles who are on traditional fee-for-service Medicare versus Medicare Advantage plans? For example, many states' Medicaid plans will not cover premiums forcing dual-eligibles to remain on fee-for-service Medicare. Is that the case? And how widespread is it? And is it a problem, I guess, would be the question?

JEFFERY CROWLEY: I'm not aware that that's the case. I don't think that's right, actually.

ED HOWARD, J.D.: If the questioner knows some specific states where that might be the case, that would be helpful. And otherwise, we'll go on. Yes, go ahead, Jeff.

JEFFERY CROWLEY: Yes, there was a question I just wanted to clarify something from my presentation. In figure 11, I showed a slide of the United States and it was titled "States Vary in Their Share of Long-Term Services Spending in

the Community." And the question was, is this showing spending in dollars or is it showing numbers of people served? And this slide does show spending. So when I said that 10 states spend more than half of their long-term services dollars in the community, it's spending. I would note that community services tend to be much cheaper. And I'd say virtually all the states there are far more people in the community, even though they're spending more money on institutional care.

ED HOWARD, J.D.: Good. Thank you for that. Question for any panelist, are there any states that currently have a successful model for pay-for-performance in their Medicaid program? It's all the rage in the private sector and Medicare has a dozen demonstrations going on. How about Medicaid? Any? I have not heard of any myself.

JEFFERY CROWLEY: Just in the last week, a report came out about how Medicaid programs are using pay-for-performance. To be honest, I don't even remember who the author was or where it was published. But it was just recently released. It may have been from the Commonwealth Fund. I'm not sure.

ED HOWARD, J.D.: Whatever it is, we will track it down and post on the All Health Web site.

TRISH RILEY: It does beg a bigger set of questions, though. The sort of rage for pay-for-performance, every payer is coming up with their own performance measures. And I think from a state perspective and from a quality perspective, it

really begs the question, especially what gets measured gets done kind of notions. And if every payer has its own set of metrics about what we ought to be measuring, recognizing that Medicaid and Medicare have different kinds of needs, you really wonder what you're getting out there in the field. And I think it begs for the attention of CMS to think about pay-for-performance standards and metrics that apply nationwide in Medicaid programs and in Medicare programs and that correlate well with what employers are doing. Or conversely, that are independent of payers, which I think makes some sense and come from the National Quality Forum, State Quality Forums.

ED HOWARD, J.D.: Okay. This question strays into policy pretty directly. But it is an interesting question. Are there any proposals to incorporate a long-term care benefit within Medicare replacing Medicaid? Wouldn't this limit the burden on states? And what would be the down side to this idea? Somebody in Congress wants to know.

JEFFERY CROWLEY: I think a lot of policymakers are trying to look for ways to take some of the pressure off Medicaid. And one way that we could do that is to have Medicare pay for a greater share of long-term services spending. There are many different ways we could do it. One we could expand the current benefits that Medicare pays for skilled nursing facilities for a limited number of days. We could expand that. We could add some sort of community living

benefit. I think the overwhelming issue or impediment really is just the federal budget picture and the concern that anything we do would be a lot of dollars. But I think there are ways to scale this up to work with however many dollars we have to do something we could do that.

There is also talk of what can we do outside of Medicaid and Medicare, but in the private market or in other ways to take some of the pressure off Medicaid so that Medicaid really isn't the only national long-term service system we have.

ED HOWARD, J.D.: Okay. Question involving foster care children. Why aren't we covering all foster care children up to 21 or 23? They have no parents. They're likely to be uninsured. They need the coverage. Anybody? That certainly does not indicate a lack of understanding of the program.

TRISH RILEY: There was a study done a number of years ago, again by the National Academy for State Health Policy looking at foster care and children on Medicaid. And I don't remember enough about it. But I do remember one of the challenges is the churning of foster children and how many homes the move to. They move from home to home, to place to place. And continuity of coverage for them, regardless of whether they have a Medicaid card or not, is a really challenging prospect.

ED HOWARD, J.D.: Okay. Diane mentioned the 5.6-percent of Medicaid expenditures going toward disproportionate share hospital payments, or DSH payments. How would the president's affordable choices plan, that plan would allow states to use DSH payments as an additional funding source for SCHIP affect facilities needing these funds? Diane?

DIANE ROWLAND, SC.D.: Well, as I said when I explained that disproportionate share of hospital payments are now allocated as extra reimbursement payments to facilities that provide a large share of their care to low-income individuals who are either on Medicaid or uninsured, that's the disproportionate share of low-income and uninsured patients. Most of these facilities would probably be delighted if we had universal coverage so that everyone walking through their door would have health insurance coverage. But in the absence of universal coverage, really do rely on the disproportionate share payments to help with their uncompensated care burden. So it's really an issue of under affordable choices, will you get toward universal coverage with it?

And it's doubtful that the volume of dollars from the DSH program can achieve in any given state enough universal coverage or having everyone covered that there won't remain an uncompensated care burden. So I think the facilities that today are our safety net facilities have expressed a great deal of concern over the affordable choices program because they are

concerned that the funds they now use to care for the uninsured will get taken away to be used for private health insurance premiums for individuals that may not come through their doors. But, in addition, there will still be many coming through their doors who are uninsured, for whom there would then be no coverage.

ED HOWARD, J.D.: Now, it is true that many of the state reform plans seem to incorporate some aspect of this kind of proposal in their financing scheme. Trish, do you have some comments on that?

TRISH RILEY: Well, Maine, like several other states, doesn't have public hospitals. And as a result, our DSH money is being used to fund our childless adult waiver. And our strategy is that you want to fund people for the services and not providers for uncompensated care and provide people with coverage. So our DSH dollars are pretty much all involved with our childless adult waiver.

And there are several other states like that, Massachusetts model uses some of its money. And I think you'll see that as the states reform health care, DSH is an important part of the strategy.

ED HOWARD, J.D.: Will any of the panelists speak about carve-outs? How you define what a carve-out is? How you determine what should be carved-out? This writer is especially concerned about dental services for children but also services

for adults with chronic illnesses like diabetes and cardiac illnesses that can lead to complicated dental care conditions. I didn't know that.

JEFFERY CROWLEY: I'm not really sure I know how to answer this question. Carve-outs are something where if a state say was going to move to manage care and they were going to provide a broad range of services through managed care, they might so-call carve out certain services and pay for those in a different way. So again, in the context of managed care for people with disabilities, some states have been worried about if they capitated everything, what would happen to access to prescription drugs? So they've carved out prescription drugs and said we're just going to pay for that on fee-for-service basis. Or in some cases, they've carved out behavioral health care services, saying, "Well, you know, this involves really specialized services. We need somebody else to provide those services." I'm not sure I can answer the part about the dental care access, but.

DIANE ROWLAND, SC.D.: Dental care is an optional benefit under Medicaid and often the benefit that in fiscal tight times is dropped for adults. It's kind of one of those bellwether. You know that states are in trouble when they start cutting provider payment rates and dropping dental care for adults. They can't really drop it for children because of the EPSDT provision, though it is an area where the

participation rates of dentists in the program have been very low. And much of the payment policy for dental care has been even poorer than the payment policy for other services under Medicaid. So it is one in which I think the benefit has often been there, but the reality of being able to get access to dental services has been very limited.

If a carve-out is a mechanism states can use to try and both boost participation and or boost payment rates, it may be very important for improving access to dental services because they really have been one of the more limited benefits under Medicaid. They've been there on paper often and not in reality.

ED HOWARD, J.D.: We are getting down to the last few questions. So I would urge you to get your last questions in if you have that in you and also to get that evaluation form and fill it out, if you would. This one asks, we've talked a lot about how variable the Medicaid program is from state to state. What are the largest variations between states that make Medicaid so complicated? Is it covered services, eligibility, or what? General categories of causes of those variations are what the questioner is seeking.

DIANE ROWLAND, SC.D.: Well, maybe one should say that the biggest source of variation is the way in which the Medicaid statute operates at the federal level. That it sets up categories of individuals who must be covered, categories of

individuals who states have the option to cover, benefits that must be covered, benefits that states have the option to cover, and then give states great discretion over their payment policies and their payment rates so that when you put all of that together there's a core that you can expect to be there in every state. But we have to keep tracking who they cover, what their eligibility levels are. They have different eligibility levels.

For example, for parents who are working and non-working, in some states they have different benefit packages for adults. And they have obviously very different standards for what they do above the federal minimums for people with disabilities. So it's literally that there's a lot of mandatory requirements in the program but there's far more optional. Two-thirds of the spending under the Medicaid program comes from options states pursue in terms of both eligibility and benefits.

TRISH RILEY: And I think states are always wanting to ask for more flexibility though the flexibility, while it can create opportunities for creativity, it also creates opportunities for more variability.

ED HOWARD, J.D.: Here's another opportunity for variability. We're beginning to learn, the questioner writes, about new evidence-based programs that improve the health of disabled and older adults, programs such as chronic disease

self-management, physical activity, and fall prevention developed with funding from NIH and CDC and HRQ, et cetera, AOA. How can we systematically inform the Medicaid coverage process so that as new programs are identified as effective, they can be covered by Medicaid?

JEFFERY CROWLEY: Again, I'm not sure I have the answer to that. I think the questioner raised some interesting areas where we're seeing new evidence. There's been a lot of excitement about how we use evidence-based prescription drug practices. I think we can learn from there there's a process based in Oregon called the drug effectiveness review project where a number of states collaborate together to do these drug class reviews. They publish reports. But the interesting thing is they rely on sort of experts on how you evaluate evidence to do these reviews. But then each state makes their own coverage decisions because each state is different. I think what we need to do is promote more of these things so both we expand the expertise to evaluate evidence and also to do a better job disseminating it, whether it's programs for a specific populations or specific services. I think we're seeing a lot of interest in that.

TRISH RILEY: And I'm not sure it's necessarily a need for expanded coverage. I would argue that states have considerable flexibility now to change incentives for providers, to change protocols and expectations. We obviously

have quality standards and can set for the care model as one of those. But I think the change at a state level is tougher when you've got a provider base used to the program. Many of the providers in long-term care and disability are largely Medicaid providers. They're not like physicians for whom a portion of their practice is made up of Medicaid. They are largely Medicaid providers. So that's an opportunity in that you can change expectations, contacts, reviews, expectations. It's also a challenge because the status quo and how funds have been going to those agencies are tough to change. But I don't think it's necessarily always a need to expand something federally as much as it is an opportunity for states to think differently about how to do business.

ED HOWARD, J.D.: We've got a couple of questions that involve undocumented aliens. One question about whether or not minor children of such aliens are eligible for Medicaid and whether that has a direct impact on boarder state's Medicaid programs. And another question that talks about the long-term fiscal implications of immigration reform that would lead to people who are now in the country without documentation becoming citizens over a period of time and, presumably, this question assumes generating more people on Medicaid over a period of time. I wonder whether panelists have talked about that or heard it discussed, what the order of magnitude is of that particular area of problem.

DIANE ROWLAND, SC.D.: One of the things that makes Medicaid complex is what the federal government will provide matching funds for and what it won't provide matching funds for. And the Congress, you all, help to determine whether there are groups that are excluded from coverage. And one of those groups under Medicaid has been not just illegal immigrants but legal immigrants within their first five years of being in the U.S. are not eligible for federal matching funds. If a state elects to cover them, they must do that with their own state funds and not with federal matching funds.

The question about children is a difficult one, depending on where the child is born. If the child was born in the United States, that child, regardless of the immigration status of their parents, is an American citizen and is entitled to be covered under the Medicaid program. However, if the child was born in the country of origin of their parent, then that child is subject to the same bar on eligibility for five years until their family and they have been in the U.S. for five years if they are legal. And if they are illegal, they remain ineligible for coverage.

So one of the issues here is rather the border states and, in fact, if you look at immigration policy and distribution, immigrants are not just in the border states. There's a higher concentration of them but they are throughout the United States. And we are really unable to provide for

full coverage for them under the Medicaid program now although we do provide for emergency services under Medicaid even for illegal immigrants when they are delivering a baby at a hospital or whatever. So many children to illegals are being born in the U.S.

But those are all very complex issues. I don't know about the estimate of over 20 years what it would cost to provide amnesty because we are still in the process of trying to get a better count on how many people are here legally and illegally. But I do know that this is a matter of different states having different levels of burden for their immigrant population. And we saw in California's health reform proposal that, at least for the children of immigrants, they were providing full coverage for them although they were still leaving adults to have to rely on a county health system if they were not legal.

ED HOWARD, J.D.: Okay. I think we have just about come to the end of our time. Let me just make one more pitch for your filling out the evaluation forms and turn, if I can, to thank both those of you who have sat through this discussion and those of you in congressional district and state offices for staying with us through technical glitches and wind storms and other difficulties. Thank Diane and the rest of the folk, her colleagues at the Kaiser Commission for their co-sponsorship and very active participation and positive

participation in the program. And ask you to join me in thanking the panel for dealing with I guess an incredible variability of topics that have been raised over the past hour in an incredibly efficient way. Thank you very much.

[Applause]

[END RECORDING]