Kids, Medicaid and Quality of Care
September 9, 2005

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[START RECORDING]

ED HOWARD: . . . a great deal of debate lately about Medicaid, especially about it's cost both to state government and to federal government. And today, although we certainly don't want to ignore the question of the program's price tag, our focus is also going to include what we get for that money, especially for the 25 million or more children who enroll in Medicaid in the course of a year. Our partner in today's program is the Commonwealth Fund, a private foundation whose work stresses the need for a high performance healthcare system that deals well with the most vulnerable segments of our society, including young children. I don't think she's here yet, but Melinda Abrams, Senior Program Officer at the Fund has done a great deal of work on today's program. Indeed, she is here, and I want to thank her for that. Ed Shur [misspelled?] who is the vice president in charge of this area at the Fund has also been very supportive, and this program has been a long time in the devise. So I am very pleased that we are getting a chance to do it at a time when Medicaid is so front and center in the public policy debate. Let me just do a couple of logistical items before we move on. In your packets, you are going to find a lot of background information, including more extensive speaker biographical information that I don't have time to tell you about. There is also a set of charts; the top one of which is labeled Children's Health Insurance Coverage

Status in type from ’87 to 2004, which is not labeled as to origin. That is something that the staff at the Alliance put together basically from census data, so we should have acknowledged that. You can view a web cast of this briefing by the end of today at kaisernetwork.org and that same website along with the Alliance website will have both the materials in your packets and a transcript within the next couple of days. There are question forms in your packets that you can use to write something out if the urge takes you, and there are some floor mics that you can use to ask questions directly, which I heartily endorse because we usually get more written questions than we can get to. And finally, this isn’t so much as a logistics note as it is sort of a warning label, we normally ask our speakers to be as plainspoken as possible with very few jargon terms or acronyms; so I want to forewarn you you will hear one set of initials repeatedly today, EPSDT. That is not an eye chart [Laughter] it stands for Early and Periodic Screening Diagnostic and Treatment – did I get that right?

FEMALE SPEAKER: Yes.

ED HOWARD: Okay. It only exists in Medicaid; it’s only for kids, and there will be a quiz on the content of it later. We have a very distinguished group of speakers today, so I want to get started right now to talk about Medicaid and kids and the benefits that are provided to them. To lead off today’s discussion we’ve got one of the country’s top experts

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in healthcare access and quality, especially for vulnerable groups like children, Sara Rosenbaum. Sara directs the George Washington University's Center for Health Services Research and Policy. She holds the Harold and Jane Hirsh Chair in Health Law and Policy at the G.W. School of Public Health and Health Services. She's an attorney who has worked on important governmental assignments; and in the non-profit advocacy world for years. And she has graced our programs a number of times for which we are grateful, and we are grateful again. Sara, would you like to start us off?

SARA ROSENBAUM: Oh, there I am. Thank you again to Ed and to Melinda and to Commonwealth Fund, and let me just acknowledge Ann Marcus who is sitting up front and whose work on all the fact sheets and the slides make them as good as they are, and Jenny Kenny from the Urban Institute who has contributed data that we'll show during the presentation. I was thinking as Ed was explaining the acronym that probably given all the attention that EPSDT has garnered over the past year, so this is the first time in the 30 years I have worked on the program that I haven't had to explain it to anybody. What I am going to do with my allotted time is take you quickly through the basics of the program and quickly give you a sense of what the proposals look like that are about to be debated. The first and most important thing to know is that the EPSDT program, and sometimes it is called a program, it really is a

set of benefits and set of obligations on the part of state Medicaid agencies, but the program did not come into existence until 1967. That is to say, children were already covered under Medicaid. They already had the basic Medicaid benefits that everybody gets, and yet two years later along came the Johnson Administration with a very comprehensive set of benefit recommendations and program recommendations for children as part of a larger pediatric initiative. And so the sentiment leading up to EPSDT was that ordinary insurance coverage for low-income populations was not enough, and there were two big drivers underlying the Administration's conclusions. One being the result of the early Head Start studies which of course involved preschool for very little children infants and toddlers; and the second and in some ways more striking source of inspiration for the program was in a 1964 Department of Defense Study, a very famous study called "One-third of a Nation", which looked at draftees and concluded that there was an astounding array of preventable physical/mental/developmental conditions that affected adolescence and that lead to about a 50 percent failure rate among draftees. Based on that, the Administration proposed a very special set of benefits for children. Those benefits in 1989 were further expanded to deal specifically with shortcomings in coverage around mental and developmental disabilities. The scope of the EPSDT requirements it's - EPSDT

is a bundle – think of it as a bundle of benefits that is a requirement of the statute and it is a required benefit for all categorically needy children; meaning, children who don't incur expenses and spend down to their eligibility. Now categorically needy children make up about 95 percent of the program as you can see. It's an optional benefit for medically needy children. Most children who are medically needy and in Medicaid arrive in Medicaid because they have a catastrophic illness that lands them there. Many come from families who are working who have some employee benefits and then whose child becomes very ill, exceeds the benefit limits, and ends up in Medicaid. Of course, for children who are covered through SCHIP the State Children's Health Insurance Program in states that separately administer SCHIP. States can but don't need to offer the full EPSDT benefit, and we've done a fair amount of research which we can get into during the question and answer about some of the key differences between Medicaid and separately administered SCHIP Programs. The core elements of EPSDT are as follows. First of all, I should back up and note one thing you need to understand about EPSDT – and I speak now I guess as a lawyer – is that the word Early needs to be understood as modifying every word that follows, so it's early screening, early diagnosis, early treatment. Early does not mean that it starts at the newborn period, it does, but EPSDT means that at every stage you intervene early. The point of

the 67 Amendments was to go out and find children and get them early treatment to ameliorate the effects of Mason's physical, mental, and developmental conditions, which would affect their growth and development. So today, EPSDT consists of periodic exams; typically the American Academy of Pediatrics Guidelines for Health Supervision is what drives state programs, just like the American Dental Associations Pediatric Exam Schedule deals with the dental benefits, but it's not just periodic exams. It's as needed exams, and you are going to see the power of the as needed piece actually in something like Hurricane Katrina where you suddenly have a good chunk of the more than one million very low-income children who are now on Medicaid in these three states who are now suffering a huge array of health problems and health threats who are going to be able to get not just a checkup when they are next due on the AAP schedule, they are going to be able to get an as needed exam. No question about it's coverage; full vision, dental and hearing care, preventative services, dental restoration, emergency care, full vision care, full hearing care, hearing aids, speech therapy for children who need speech therapy for hearing disabilities, the works. And finally and probably the most controversial part of the program, EPSDT requires that states cover, if it's medically necessary, all of the treatment and services that are listed as part of the definition of medical assistance. A lot of the services that fall into the definition of medical

assistance are optional for adults. If a child needs a service even if it's not available for an adult or if it's available only in a limited amount for an adult it must be provided to the child, so an easy example would be rehabilitation services. In the case of an adult, a state may impose severity tests on medical necessity. The state may limit the number of encounters in any given time period, may impose a restoration of functioning tests on whether the benefit is medically necessary. In the case of a child, the issue is whether the clinical evidence and the best research that is available suggests that the child needs the intervention to ameliorate a condition that would affect development. It's a very different standard. So a toddler that is not developing fully, and Christy is going to talk more about this, would get rehabilitation services as well as other preventive services for the amount of time it took to catch the toddler up, as long as the clinical evidence suggests that the catch up is needed. There are a series of administrative activities states must carry out; informing, scheduling, transportation, and the state has to maintain relationships with the Child Welfare Program, Special Education Programs, WIC, Early Intervention for Children. EPSDT's mission sort of runs alongside these other missions. How does EPSDT differ from SCHIP? The two can actually be exactly the same. It's a state option, but typically what we found in our own work is that EPSDT packs a

bigger punch benefit wise. The assessment protocols are more detailed. There is typically a little bit more coverage in the way of vision, dental, and hearing. The benefits for treatment and diagnosis may be broader. The medical necessity standard is sort of within the federal Medicaid framework in the case of EPSDT. In the case of SCHIP, insurers who sell to SCHIP plans can use a more actuarial and common definition of medical necessity; and of course the cost sharing rules differ. EPSDT helps a lot of children, and we thought it would be interesting to give you a little bit of data from a forthcoming study we are doing for the Robert Wood Johnson Foundation just on children in the military. Children in the military, of course, have parents who get employee health benefits; they get them through the military. There are two million children in the military; about 8 percent have supplemental coverage though Medicaid, so a lot of families on military bases have their children enrolled in Medicaid if they have special needs. And as you can see, these children tend to be disproportionately non-white, disproportional low-income, are much more likely to have special needs, of course, and are also heavy users of services through state maternal and child health programs, another source of supplementation of the military health system. This is just a quick set of examples of children who benefit. Healthy infants and toddlers who need primary prevention, their families need the kinds of services that all

families need. They need guidance on parenting. They need the as needed checkups. They need vision, dental, and hearing care, and routine parenting support. Another group of children though at the opposite end of the spectrum who benefit very greatly from the program are, of course, children with profound disabilities. One of the most startling examples of these children which has received a lot of attention this summer because of the seriousness of the problem in the U.S. are children born extremely prematurely, so children who are a thousand grams and under who now survive at great rates need the interventions that EPSDT provides because of their growth and developmental delays and the risk of delay. Children in foster care and child welfare systems are tremendous consumers of EPSDT diagnosis and treatment services and, of course, children with special education needs. This just quickly shows you how important it is to think about EPSDT in terms of all children and not just the children with the most severe disabilities. In fact, among children generally, children who get the Medicaid through SSI the Supplemental Security Income Program are a very tiny fraction of all children. Most children who have some sort of functional limitation have come onto Medicaid as a low-income child or through the child welfare system, not necessarily through SSI. This is another slide that shows you the same point. If you look, you will see that in fact only a minority of children with chronic

conditions come to Medicaid through SSI; the majority come to Medicaid simply as lower income children. Another interesting cut at children again is, of course, how they fair in the cost of Medicaid. EPSDT is a very comprehensive benefit; it's of great importance to children for preventive services and more high cost services. Children are, of course, a small part of the high cost Medicaid population. The world would be a strange place if it were any other way and luckily children show up significantly, but they certainly don't dominate the high cost population; they do dominate the low cost population. And I think most importantly that even with this comprehensive benefit, children are very low cost. They are low cost in relation to all Medicaid enrollees; total spending on them is about $1300 in 2001 related to $4000. This is with the full benefit loaded in, and even compared to privately insured children who are not as well insured children once you control for their health status and their income turn out to be cheaper in Medicaid, even with the better coverage than privately insured children. Just briefly before I close, there are a series of reform proposals. The President and the Medicaid Commission recommend no direct changes in EPSDT. There are recommendations for changing EPSDT from the National Governor's Association and the National Conference of State Legislatures. In the case of NGA, NGA would loosen really the diagnosis and treatment rules for that small slice of children whose coverage

is optional as categorically needy children or the medically needy who can also be covered through SCHIP, which does not carry the EPSDT requirements. The National Conference of State Legislatures actually appears to broaden its recommendation to relax the coverage rules to all children would leave screening, periodic screening, as a benefit, eliminate the diagnosis and treatment requirements; although, appears to recommend leaving the dental requirement in place. Finally, some of the more recent 1115 proposals do recommend or seem to imply waivers in EPSDT coverage. Only once, interestingly, has the secretary waived EPSDT for mandatory coverage groups and that was under President Clinton for the organ-rationing plan. Several of the proposals now moving toward a full consideration involve the substitution of a much more flexible benefit package coupled with high deductibles and cost sharing in the health savings account approach for everybody or for certain subpopulations, and for that, of course, EPSDT would be waived as a benefit. So I will close there.

ED HOWARD: Thanks very much, Sara. That's as clear an explanation of that package of benefits I think that I have ever heard. Now we are going to hear from Christy Ferguson, who most of you who have been in this health policy game for a while know, was for many years the counsel and a senior staff member for the late Senator John Chaffey of Rhode Island. She also ran the Medicaid program later in Rhode Island. She

directed the Massachusetts Department of Public Health, and now she heads an effort, a bipartisan effort, called the Children's Investment Project, a new national advocacy effort on behalf of children. She too holds a law degree, and she too has graced the Alliance programs in the past and we are very happy to have you back, Christy.

CHRISTY FERGUSON: Thank you very much, Ed. [Inaudible]

FEMALE SPEAKER: Your mic.

CHRISTY FERGUSON: How's that, better?

FEMALE SPEAKER: Yes.

CHRISTY FERGUSON: I am going to take a little bit different tact than Sara took and leave you with some thoughts and ideas around the possibility of Medicaid reform. I have as Ed said spent 14 years at the federal level on Capitol Hill just in the same roles as many of you are playing now, and 10 years in executive branch government at the secretariat level working with two different republican governors who are republican governors in arguably the most "liberal" states and most generous states from the prospective of Medicaid in the country. And what I would say to you is that from a practical prospective on the ground, Medicaid reform is not only ongoing but it is extremely strong, and although the federal government hasn't taken and Congress hasn't really taken a clear prospective on Medicaid reform particularly as it affects

children and families, clearly the states have and are and will in the future. And the reason for that is that every state budget has to be balanced at the end of the year, so even in those states that people perceive to be very liberal and generous in their benefits package, the amount of time and energy spent on reforming the services that are delivered under Medicaid is immense because Medicaid is the one uncertainty every year in the budget. The last two months of the budget cycle in every state is spent trying to figure out what actually has been spent in Medicaid and what is likely to be spent in the last couple of months, and therefore, how much of the budget has to be reallocated from other important programs. And so resentment even in those states where the predominant party is democratic in the legislature, resentment of Medicaid is growing by leaps and bounds, and I think that that is very important for people on the Hill to hear because we tend not to think about it from that prospective. The time spent in states on Medicaid is inversely proportional to the time spent at the federal government level both in the executive branch and in the Congressional branch on Medicaid, and I think that's also a critical thing for people to remember as we talk about Medicaid reform. The reach of Medicaid in states is vast particularly with regard to children and families. The truth is that Medicaid is in fact the glue that holds together all of the social services, healthcare, and yes, criminal justice programs

in states; and without it, those other programs that you appropriate and those other entitlements would fall apart. And so somehow looking at how this program has actually developed in states is absolutely essential. So from my prospective, the question isn't will there be reform in Medicaid, but the question is will there ever be ever be a federal vision of what reform in Medicaid should look like because the truth is we are reforming it on a day-by-day basis in the states. I think just some thoughts as you think about EPSDT and healthcare for kids, the critical issue for children and families is healthcare. It's not necessarily health insurance, I would argue. Medicaid and SCHIP have become a key way of providing healthcare to children and families and ensuring that their health status is maintained or improved. A third of kids in a lot of states are covered through SCHIP or Medicaid; most of their parents have multiple employers. They are working parents and they have multiple employers and they don't have access to group insurance. My concern is that what we ought to be looking again at is the outcomes of healthcare and understanding that there is a difference between a poverty program that is designed to ameliorate poverty and healthcare and what we are trying to do with healthcare. The goal should be, and is in fact in states, to improve the status of kids' health so that they can be educated so that they can leave school ready to learn and ready to lead productive lives. I would ask you, you

provably are all too young for this, but has anybody ever had an abscess in their mouth, ever an abscess? You are way too young. What about an impacted wisdom tooth? Okay. What about a broken leg before it gets set? Boy, you guys are a really healthy group. [Laughter] If you can imagine an abscess for a minute is unmitigated pain and the issue for a state is if you've got kids, which we do, we have a lot of kids in school who have cavities and abscesses that are so painful, they can't even hear the teacher and there is no way to treat them, or if they are being treated – so the issue for us as a state is how do you look at that child and make sure that the services that are being provided are being provided so that that child can learn because if that child can't learn, it's an added expense to the educational system. And it's ultimately an added expense to local government in terms of criminal justice, in terms of after school programs, and a series of other things. So there is a reason that we have to treat and think about children's healthcare and their parents because that's the key way that kids get their healthcare delivered. We have to think about how we are providing those services, and we have to focus on it because it has a tremendous impact – just forget the moral issues – tremendous impact economically on the rest of what we spend as taxpayers to provide services to kids. Again, the purpose of healthcare to kids and families, I would argue, and I think that it's demonstrated at the state level over and

over again, is not to insure against catastrophic health problems. It's actually to ensure that kids enter school ready to learn and leave school ready to lead productive lives, and are able to be good parents as they go along. Those are really the outcomes that we are trying to achieve. I think we have a tendency particularly at the federal level to think about things in a very paternalistic way, and if I can make this work I want to push to – this is my favorite slide. This is in your briefing; it's on page four. And I am only going to use this one, but there are a couple of other slides in the presentation that might be helpful in thinking about this. One of the things we did in Rhode Island specifically around Medicaid and moving to managed care, so moving from a public claims processing kind of system to a Medicaid managed care kind of system under tremendous objection from almost everybody; advocates, providers, was to look at providing services in the private sector system for people who had been in a public sector claims payment processing. And so what you see in terms of the gap here is the difference between on the top lower income families who receive their healthcare though Medicaid and on the bottom upper income families who receive their healthcare through their employer predominantly. And one of the things we did was to number one, define medical necessity; okay, so when we went to the private sector and bought coverage, this is what we required. We required that medical

necessity would be maintenance, maintain or improve health status, so it wasn't just improve it was maintain or improve. The second was that we required the commercial and the public side to use the same network of providers. And the end result was within 18 months of implementation, women who were low income and who, a lot of people argue don't make good decisions, made exactly the same decisions as women who were upper income with regard to how quickly they had second births delay or extended period; and this is important because if a birth occurs within 18 months of the first, you have a higher risk of a whole series of developmental issues. One of the reasons that Rhode Island has not cutback their eligibility is because of this chart and the reason is because not because – I've got to be careful about how I say this – it's not because there is a moral issue and we really want to make sure that people get the best coverage; that's clearly one of the motivating factors but probably as important a motivational factor, was what is the impact of this delay, and in some cases avoidance of a second birth on the education system and on the special education rates. That connection was critical to Rhode Island. Another example in the same vein is lead poisoning, and this is again an EPSDT service. What we had was, if you can see this chart, on the commercial again upper income families about a 7 percent rate of lead poisoning; for lower income families we had a 17 percent rate of lead poisoning.

Now what does that mean? It's a huge expenditure on the special education side, huge expenditure on the education side for the state, but the private sector really is not geared toward dealing with these kinds of programs, the private health insurance programs, because they don't generally have to deal with kids who have lead poisoning. That's not true when you have predominantly people in an aging housing stock who rent, so this issue of how you meld the private and public sector is absolutely essential. I am going to skip ahead. Those are a couple of examples of the kinds of things that you have to think about in terms of revamping the system. So the number of kids who have special needs that the private insurance industry does not recognize or isn't used to dealing with the sheer number is significant, and so if you look at what we buy from the private sector versus what the private sector can buy from us, from state systems, and you truly meld those two things; you have the potential of having a very lower cost and effective kind of program. So I would argue, you buy into private insurance for those things that private insurance does really well, and on the reverse side you allow upper income families as well as private insurance companies to buy into state systems that provide the kind of wraparound services that are necessary for a small number of kids who have special needs. And the reason you do that is not only because it's good for the health outcome of the child, but also because it's

essential for the cost of education services and for ensuring that kids are going to leave school ready to learn. So in terms of thinking about reform and thinking about EPSDT and children, just a couple of points; one is that we should seriously consider separating the services that are made available to children and their families from all of the other populations within Medicaid. We should look at them differently because they are in fact different. Kids need different services and need different systems than adults do. We should separate them out. We should continue with the melding of the private and public sectors in terms of both coverage and delivery systems that people who are lower income families make the same kinds of decisions that upper income families make when it comes to their healthcare if they have access to the same delivery system. And so if we are going to do this we have to make sure that they have access to the same delivery system and that means some degree of regulation that some people might be less comfortable with; that services that the private sector doesn't cover normally should be looked at as wraparound services and should be purchased – people should be able to purchase whether they are upper income or lower income based on their kid's special needs; that definitions of medical necessity have to be clearly indicated in any kind of a program that develops around children and families' health; that premiums are important, co pays may be a barrier, but

premiums in fact are important and a key component of anything that we do going forward; and ultimately that this is not a poverty program. It should not be a poverty program, it should be healthcare program, and we need to look at it that way because we do not have the demographics to support the next generations of Social Security recipients. We don't have the demographics in terms of kids to be able to support the level of debt that we have. We have to make sure that each of our children is properly cared for from a medical prospective, and that that allows them to learn and to become productive in ways that allow us to continue to have a strong country, and that needs to be the focus of our reforms. In terms of the one last thing which is the legal aspect of EPSDT, the reality is that the waiver, the process of waivers and the process of some of the changes that are happening, are in fact, eroding some of the legal components of the entitlement in Medicaid. And I think we need to recognize that and we need to think about what we actually want because trying to fight against it and put blinders on about the fact that it's happening, I think, is a mistake. We need to really embrace this. This is the one area in healthcare reform that there can be bipartisan agreement around in terms of children and families, and we really ought to make it a priority. So thank you very much, and we will go over to Nina.

ED HOWARD: Let me just say a word. Thank you very

much, Christy. As Christy indicated, our final speaker is Nina Owcharenko, who is a Senior Health Policy Analyst for the Heritage Foundation in their Center for Health Policy Studies. She has written, as there are examples of in your materials, a wide range of topics including Medicaid. Now before she joined Heritage, Nina spent almost a decade on Capitol Hill exclusively with members from North Carolina, and her degree is from UNC Chapel Hill. I wonder what that's all about, but maybe we will get a little bit of that flavor maybe the North Carolina Medicaid Program reflects your influence. Nina, thank you for being with us.

NINA OWCHARENKO: Well thank you for having me. I wish I could say that it was North Carolina's Medicaid Program that inspired me to get into healthcare policy, but like many of you staffers out there, you get stuck with an issue when you start, and you just kind of learn it on the ladder up, so that's how I ended up in healthcare policy. But it has been an interesting ride for me, and I have to say usually on these panels they try to kind of create a little bit of like not a crossfire balance, but saying one side thinks one thing and another on this side, but I was actually very pleased to hear this discussion, and I think you are right. There is a lot of bipartisan potential here in looking at what we should do with the Medicaid program. I thought that the slides were very interesting highlighting that children are the least expensive in this area, as well as

the reforms that states are going to be taking whether or not the federal government wants them to go about it that way. Medicaid does, I think, play a very critical role in providing needed care to children. I think that's one of the reasons why it was created. It was created to help pregnant women and children. I think that over the time what we have seen though is states trying to fill in the gaps in other areas. We see them have expanded coverage to the disabled population, not just children that are disabled but elderly populations, the working poor, also childless adults. We see more states trying to reach out to take care of those lower income families, I mean, individuals that are not part of a family structure, but as this evolution has occurred, you can see what happens which is it puts pressure on the entire program. So these well-intentioned kind of processes of evolving into a larger program may have somehow skewed the real focus of what Medicaid is supposed to be. And to react to that what we have seen over and over again in the states are very much looking at well how do we control these costs. Now, I know this panel isn't about the budget and cost, but it's an important factor that must be brought in to understand what is happening to the program. So when you look at what states have done, they have started looking at coverage, services, access. Those are the areas where they have the controls immediately with budget numbers to kind of make the budget work for the end of the year. That is

something that is inevitable and states will continue to do that, and also as was already mentioned, the Medicaid program this impacts beyond. I mean, we know that it is taking away from educational spending; it's taking way from transportation spending. There are a whole host of other priorities that are now getting possibly in the other groups' mind shortchanged due to the increased growth in the Medicaid program, and so I think that the whole discussion of Medicaid reform and how I say thankfully it is trickling up to the federal level, at least there is now becoming a discussion about Medicaid. I do agree it is completely skewed. States are far more involved in what's going on with the Medicaid program than I think federal policymakers are, but I think it also brings to the head the classic conflict that you have of trying to provide everything for all, and I think that's what states are continuing to struggle with. And I think that we could look at a list of conferences and briefings that have gone on for the entire month or ever since the budget reconciliation was put forth of other groups talking about very similar ideas, but on specific populations. You could see long term care issues, whether – you know, how do we deal with disabled populations? What about the uninsured? Should Medicaid be filling in the gaps there? So there is a natural conflict that occurs for policymakers, and where they are actually going to have to make tough choices. You have to understand that there are limitations on

what can be done and you have to make tradeoffs in that type of an approach when you look at reform. You have to look at poor children versus those on the upper income. Some states, as pointed out, do have people upper income children qualifying for the Medicaid program. Policymakers have to decide where the focus is going to be. Should we focus on the poorest of the poor children first, and then see what can we provide up the income scale? Is it ideas of what they can afford, can a family contribute something towards a co pay? Can they contribute something towards a premium? I think those are some choices that policymakers need to look at as well as the large issue that I pointed out, children versus the other populations that Medicaid serves. As you try to provide the best packages you can to those on Medicaid, surely you are going to take away services to those on the other side whether it's services to nursing home for the elderly, whether it's not being able to expand to childless adult populations. So I think that that's an important feature when policymakers are looking at how to reform the program, how not only to get it under control fiscally, but then how best to deal with which are the populations you want to deal and focus most on. That segues into kind of my thinking of where the Medicaid program should go and how should we start thinking about it. The most important feature, I want to point out, is that I think that we need to make sure we are persevering that state ability to make

decisions on their own. Too often, when federal policymakers do get involved, they kind of set a one size fits all that now all states are going to have to kind of obey by and make sure that they check the boxes and fit the holes of the program. I think it's more important that we focus on protecting that state flexibility, but also setting clear criteria what you want that state to accomplish. Do you want to increase better outcomes in the way that the children receive their care? Do you want to focus on making sure you have quality care for nursing homes? I think all of those things federally have a very proper role. It is some federal dollars that are used to go to the Medicaid program, so I think it's important that the federal government set some criteria and some benchmarks of what they want, but then give the states the ability to utilize and experiment with some different approaches that will reach those criteria. Two areas in particular, some of which has been reflected earlier, that we have been trying to talk about and encourage kind of the vision of where we could see. One is the premium assistance, utilizing Medicaid dollars possibly supplemented with a federal tax credit to enable some of the working poor families – these aren't the poorest of the poor – but maybe working poor families where children are eligible for Medicaid. Maybe their parents are in a private policy through their employer et cetera, and teaming those dollars up and allowing the child to join the family policy in the private

sector. Issues of wraparound could easily be seen to fill in the gaps, maybe it would be an SCHIP wraparound, maybe you could say the services – it's a very unique idea what was talked about of filling in the gaps of those really almost public health issues that are facing the insurance system, not the insurance itself. The other area is something that actually the Alliance had a briefing on I thought went very well on the cash and counseling programs that have been models to utilize how do we engage the patients, the individuals who are on the program to feel ownership in what they have. How do you encourage them to be active participants in the healthcare system? I think that it helps to create better care management for these individuals as well as giving them the ability to make the choices that they feel are right for themselves and their families. Even reward programs of rewarding good behavior if it's making sure your children go to the dentist, and giving them an additional subsidy of some sort. And I know that in both South Carolina and Florida have similar concepts of trying to set up ways to kind of engage consumers a little bit more in the way that they are going to be utilizing their healthcare services. So I think that the most important thing from a policy point of view is how can from a federal level the obstacles that sometimes face the states and making some changes are removed, that we make things easier trying to pull various policy initiatives together, not just focusing on

Medicaid and isolation of any other kind of health reform proposals that are out there. And even not isolating children out of it, how do we look at the entire population itself, and making sure that the pieces fit together so that we have a more streamline and a continuous way of looking at healthcare for low income people and especially for children all together. And I will kind of leave it at that.

ED HOWARD: Thank you very much, Nina. We are going to get your questions now. I remind you there are green cards in your packets, there are markers right there. And I should just take this opportunity, I did not mention it before, to say that those of you who are going to have to leave, we want you to fill out this blue evaluation form. We've tweaked it a little bit so it's not exactly the one you have seen in the past, so that we can make these programs as good and responsive to your needs as we possibly can. We have a couple of questions that were submitted in advance. While you are getting your questions written and your legs to propel you to the microphones, I will start with one of those. This questioner asks for some proven examples of state and local health agencies or programs – I'm sorry of programs that state and local health agencies can model their health services for children on. I presume that would include both public and private examples if we have them.

CHRISTY FERGUSON: I will give you an example of a

program that was developed in Rhode Island which actually both the private and public health sector buy into, and that is when you have a child who is demonstrating some kind of a developmental delay where you have a special ed kind of issue that may be developing and you get a whole series of different, from a practical prospective, there are a whole series of different evaluations that get done, and particularly with regard to special ed programs. And one of the things that we created was a couple of entities within the state that would provide referrals to individuals who needed those kind of services and who then would be responsible for working with that family on an ongoing basis, and getting all the data back from all of the different providers that that family had to deal with over the course of their tenure in the program. And that then would hold the providers fee to the fire in terms of actually providing those services, and it's about five years old. Blue Cross Blue Shield has actually paid for private for commercial clients, employer-based clients, to get that service because they do not have a mechanism to provide that kind of intense management and follow up with data. And so over the course of the next few years, we will get much better data on mental health, access to metal health services, access to all of the kinds of services that you all hear from on a regular basis in your state as not being available to people. So that would be an example of the kind of thing that would help do

some wraparound to private coverage.

ED HOWARD: Sara?

SARA ROSENBAUM: There are several areas where these kinds of collaborations are pretty common across states, and you find a lot of literature, a lot of evaluations of how well they function, and invariably what the evaluation suggests is that they do what they are supposed to do in terms of inputs and outcomes. Child Welfare Agencies do a lot of cross collaboration with the Medicaid program and their local health departments. So for example, where a family is in the Child Welfare system the child has not yet been removed, Medicaid funds might be used to provide very enriched services to teach parenting skills, anticipatory health guidance, do home check-ups to get a child very often, of course, one of the great stressors in a family are a child with a disability, so a child may receive extra services. And then if you look at measures of family retention as a family unit there's an effect. School clinics are another example where you find collaboration between public health agencies and Medicaid. Services for children in the Job Corps can find collaboration, so Medicaid as Christy pointed out is simply a way of financing a lot of health interventions that children need particularly when they have risks.

NINA OWCHARENKO: I just wanted to add too, it would be very interesting as we hear about proposals about health

Information Technology and how to integrate those and their application to actually much harder to impose those in the private sector, but what an interesting experiment it could be to put them in certain Medicaid programs to see how they could manage and collect and do better at kind of case management, making sure that some of those services are being utilizing, et cetera. So I think there is a great potential in utilizing that proposal initiatives as well.

ED HOWARD: If I can just follow up on that, Nina. One of the questions that was submitted in advance talks about the fact that healthcare IT could have a transformative effect on the nation's healthcare system, and want to know how to ensure that Medicaid and the vulnerable populations served by them aren't left behind given the large capital investment that is going to be required.

NINA OWCHARENKO: I would just add that I think that the best place to start with these health IT initiatives is in the public programs where you actually do have governments in control of accessing the data and the information. Learning how to knockout the kinks and then maybe others in the private sector will adopt them as well.

ED HOWARD: Sara?

SARAH ROSENBAUM: Yeah, right now the way Medicaid financing is structured a lot of – putting aside the large upfront capitalization costs – the ongoing operations of an IT

system are essentially envisioned in the way Medicaid is structured, and there is no reason why states would not have the flexibility to combine in their normal payments to providers an additional amount of money for assistance in supporting the information the IT part of a providers practice. It takes money in the sense that it needs in increasing the amount of compensation, and so whether or not federal funds would give a preferred financial contribution for IT related activities is one question. In terms of the capital startup costs, this is a huge issue. Obviously, now that CMS has stepped in to make certain software programs available, this helps to some degree. This is a big issue for Medicaid programs to think about in collaboration, I would say, with their huge safety net providers in particular, community health centers, public hospitals, and health systems, and certainly, to partner in terms of the compensation with large private providers that see a lot of children like Pediatric Society.

CHRISTY FERGUSON: A simple bill that you could write that would make a huge difference, that would make a huge difference to states being able to actually mange their costs and look at what's happening with Medicaid across the board would be to allow or to require that the feds give Medicare data for a particular state to the Medicaid agency to the state, so that they can look at and do some comparisons around the kinds of services and the costs and benefits that states

are receiving. That would be an extraordinarily helpful thing at the state level.

ED HOWARD: I should say, by the way, that Monday you will be receiving an announcement of a briefing that the Alliance is not holding but helping the *Health Affairs Journal* hold a week from today in this room on healthcare IT featuring among other Dr. David Brailer, who is the HHS Coordinator on those issues, so I hope to see you back there then. There's a question here, Christy, you seem to be drawing a lot of fire here.

CHRISTY FERGUSON: Uh-oh.

ED HOWARD: Could Ms. Ferguson state more about her comment that premiums are important but co pays may be a barrier. Why are premiums important, and why aren't they a barrier, too?

CHRISTY FERGUSON: I think that premiums can certainly be a barrier. It depends on where you put them in the income scale. So what I am saying to you is that I think that it is important from an ownership prospective as well as from the prospective of how the general public views the programs that payment is made at some income level, and that that payment depending on your income level goes up. I think that when a co-payment is used particularly around pharmaceuticals and around specific services at the time that the service is really needed, that when you are dealing with families whose income is

week to week, you know, people don't understand if you have three kids, they all come down with something at the same time that can be treated with an antibiotic and they have a $5 to $10 co pay on the antibiotic, that's $30 out of their weekly budget. And what happens is just from a practical prospective, they end up sharing the antibiotic between kids, they don't go the full course, and then you develop, you know, the whole issue of overuse and inappropriate use of antibiotics. So I think that the co-payment issue is harder because it's designed to decrease utilization and in fact, that's exactly what it does. It doesn't distinguish between unnecessary utilization and necessary utilization; whereas a premium is something that you are planning out in advance. You know how much you owe. Generally, people then understand that you are paying towards your coverage and I think that's an important piece. But, yes, if it's inappropriately applied, it can be a barrier as well. And I do think that people have a much more appreciation of this after Katrina. I was amazed at some of the coverage because I don't think people understand how many families really do operate from a week-to-week basis and don't have bank accounts and don't have the kinds of things that we take for granted. And I think that that's where I kind of come down on premiums versus co-pays.

ED HOWARD: Thank you. A question for Nina; a staffer asks that or observes or judges that you seem to emphasize

outcome measures as marks of implementation to assess compliance with federal requirements by the state programs. The question is, are their sufficiently robust outcomes measures to make this kind of determination?

NINA OWCHARENKO: Well, as with many words that we use, there are many definitions of outcomes just like there are many definitions of what is best practice et cetera. So I think that you can clearly set up different ways of defining what you would want as an outcome versus you could have them very clearly. Are you reducing the – you could look at different data points. You could say how many children are going to the emergency room per year. You could look at different areas in trying to look at ways to kind of bring down the inappropriateness, making sure that people are getting the services, kind of using the carrot and stick approach in this outcomes measure. It's not necessarily – it could include but it would not necessary have to – but I think it would be beneficial outcomes, showing that there is cost reduction in the program somehow. I think that even though states may cringe to hear that, they are doing it anyway. But making sure we are doing it in an efficient way would probably be better suited, so it depends on how you define outcomes.

CHRISTY FERGUSON: I go back to that inter birth interval chart over and over again, and the reason that I go back to it is that most states don't measure those kinds of

things as outcomes, but the reality is that even though we have had a reduction in emergency room use and a whole series of other things, that chart was the single most important chart for members of legislature because it was clear what the impact was across the board on education, on a series of things. And over the course of five to six years it's been clear that the savings from delayed or avoided second births – and this doesn't deal with abortion none of those issues are involved in this – this is literally just people changing the way that – my worst headline as a state official was the HS director said, people should stop having sex [Laughter] you know, but setting that aside, the issue was literally around, you know, how people, how women, were able to deal with their reproductive health and decisions about having a second child. But the long-term cost savings from the decisions that women made were extremely significant in Medicaid as well as across the rest of the system. So longitudinally that we were saving, and it doesn't sound like enough to you guys because the decimal is over here, but to a small state, you know, $10 to $20 million dollars over the course of five years is a huge amount of money that can then be reprogrammed into other services. So the outcomes, I would argue, shouldn't be only process outcomes and outcomes related to service used, they should be outcomes related to actual health status and improvement. And states are worried about doing that because what if it doesn't look

good. We can do process things that we can really improve, but health outcomes that sounds like something that you can't approach. I would never have predicted that within 18 months you would see the kind of change we saw – never in a gazillion years. I was terrified to have that as an outcome. Terrified. But every outcome measure that we picked like that showed this dramatic change in behavior, and I think we have to be willing to take a look at that in a much more serious way.

ED HOWARD: Identify yourself.

JOHN RING: My name is John Ring. I am a Robert Wood Johnson fellow working on the majority staff at the Health Committee. In my former life, I was a pediatric provider serving a patient population that was 60 plus percent Medicaid waiver, and a thing that I observed was a real disconnect between the screening/diagnostic function of the EPSDT program and the treatment function. It's easy to attribute that to inequities in reimbursement and I think that is part of the problem, but I would be interested in the panelist thoughts as to whether there is more than that; for example, workforce issues.

ED HOWARD: Sara.

SARA ROSENBAUM: I should note, of course, that the problem of access to treatment and also access to complex diagnostic services has been a function of the Medicaid program since its enactment. I was – before I came over here today, I

was rereading for a paper Robert and Rosemary Stevens' epic study Welfare Medicine in America which is probably the greatest history of Medicaid ever written and it was written in the first half of the 10 years of the program's existence. And you know, if you read it, it's like nothing has changed in terms of the challenges that are faced. The program was seen as untenable I should note a $9 billion dollars and the issue was how to fix the program. So at any rate, there are a couple of ways in which a managed care arrangement which is typically what you find in a demonstration state can make the specialty service access problem better and there are also situations where it can make it worse. It can make it better if you insist when you are buying the services upfront as a state that the system is able to demonstrate to you pediatric specialty shops, you know, can it deliver. Does it have the right affiliations and commitments from specialists such as they are in states; and there are a lot of states where there simply is not enough pediatric specialty services. Interestingly, EPSDT's origins were an effort to try and stimulate among others – it was one of the things that the whole package was designed to do, was to stimulate the growth of pediatric subspecialties in the United States. Managed care can also – and then I should note as a follow up to Christy's point and Nina's point – that if you then choose some performance measurements in your managed care oversight designed to test

the prevalence, access to low prevalence care, that's a good thing to do. So children with developmental disabilities or physical or mental disabilities what are do their intermediate outcomes look like. And one place where I think everybody agrees we could improve Medicaid tomorrow is to try and get Medicaid to lead the way actually on some common quality improvement measures for high prevalence and low prevalence conditions. This program is now buying about 1 out of every 4 children's healthcare in the United States, and so if Medicaid decided like Medicare does in the case of elderly populations that it's going to insist on some benchmarks of performance, it would end up having a major spillover effect on the private market as well. If you don't think about these things when you execute a managed care agreement, you can end up with a peculiar problem that we have documented extensively in our own work, which is a lack of clarity about which aspects of child health and managed care company is responsible for and which aspects remain a direct responsibility of the Medicaid program. And you end up throwing children into sort of nowhere land which is the one thing you got to think through – there are a lot of things to think through – but one of the things you think through if Medicaid were to supplement private insurance which is at some point the two systems meet up and if you are not careful about how you construct the arrangements, both sides say well that's the other guy's problem. And it's not

that it can't happen, it can, but it's an important issue. I would say that in a lot of parts of the country now we are also dealing with just an out and out workforce problem. If you need to find child psychiatry, it doesn't exist. It doesn't exist whether it's a very poor child or a middle-income child, and so this is an issue that not only Medicaid should be tarred with.

ED HOWARD: Nina is going to have to leave us now. She broke away from another conference that she was participating in to join us. I want to give her a chance to get in a last word before she leaves if she would like to. You need not if you prefer not to.

NINA OWCHARENKO: Well I guess I would just like to say that I think it does show that there is some common ground and that if we quit looking at maybe the weeds and the minuses of things and begin to look at where there is some similarities in ideas and ways to move forward, I think there could be a great success and bipartisan effort.

ED HOWARD: That's a comment completely in keeping with the tenure of the Alliance for Health Reform, and I am very pleased that you made it, and thank you again for joining us. I do want to continue because there are a couple of questions that I want to get in before we have to call it quits; and this one gets directed to Christy. There is an assertion here and then a question. The statement is it's not enough to just

treat conditions such as tooth decay, and neglect to educate parents about dental hygiene. How is Rhode Island or how was Rhode Island responding to preventive care through education if at all?

CHRISTY FERGUSON: That's a very good point. We particularly when you have populations coming from different cultures, we for example, had a huge number of women who would put honey in the formula for their kids and that caused them some – but there are some cultural issues as well. As the parent of a 13 year old with braces, you know, I know all about hygiene, but that doesn't mean I can make them do it. [Laughter] But having said that, I do think we don't do as good a job as we need to do in terms of education and prevention. The public health sort of aspects of this are significant and that kind of gets to the issue of really how do you combine public health education prevention components with a payment for services component. And so I don't think we do a good enough job by any stretch of the imagination in terms of educating parents about dental hygiene. I think that that's important, but I do think that there are – the other aspect of being able to treat kids, particularly around dental services in states is just so significant. And dental pain, if you've never had dental pain, I had an abscess, which is why I asked the question. I had an abscess for the first time in my late 40's and I literally; I could not get into see someone, no

matter what I paid. It didn't matter what I was willing to pay, and listen, I was the Commissioner of Public Health for crying out loud [Laughter] and I couldn't get in to see anyone. It was over a long weekend. I had three days with an abscess. No amount of Vicodin or painkillers did anything. I sat and sobbed and at the end of that, I said if I could make every person in the state legislature have an abscess for two hours – never mind three days – we would have no problem with dental services. And there are literally kids who are sitting in school with that kind of pain, and I just don't think any of us really grasp it because we are all middle class. Everybody sitting in this room is middle classes families. It's just like the Katrina stuff with saying I can't believe people live in such poverty in the United States. Well they do, and there are things that they have to cope with that we just don't even think about when we are drafting laws or developing managed care contracts. And I just think we have to be more aware of those things, so I don't know how I got off on that tangent, but prevention is not – we are not doing a good enough job with prevention. I am totally there with you, but we still have to worry about the treatment side.

ED HOWARD: Sara.

SARA ROSENBAUM: I should just note that one of the great strengths of the EPSDT benefit is that there are specific coverage for anticipatory guidance, which is a fancy schmancy

way of saying, you can build into the coverage and payment system for EPSDT specific time whether it is part of a routine visit.

CHRISTY FERGUSON: Oh, yes, yes.

SARA ROSENBAUM: Whether it is separated out, and done as a longer one on one in the home visit.

CHRISTY FERGUSON: Right.

SARA ROSENBAUM: Anticipatory guidance is explicitly a function of the program as opposed to something called the well child exam where actually there's no articulation of anticipatory guidance; it's simply you know a series of tests and procedures. EPSDT is all about trying to get in and talk to families, a very interesting emphasis.

ED HOWARD: Let me just finish up here with a couple of specific questions that have come up from the audience. Let me remind you that you should be using these last few minutes to start working on your evaluation form.

FEMALE SPEAKER: Give good grades.

ED HOWARD: Give them good grades they deserve them. Here's a very straightforward questions. How does EPSDT work in the District of Columbia, which those of you who vote for people in the District of Columbia know is not a state?

SARA ROSENBAUM: For Medicaid purposes it's a state. D.C. is a state; it has a state Medicaid program, and it has an EPSDT program as any state would. In D.C. most of the children

who are on Medicaid are enrolled in fact in managed care plans. There is also a special needs plan here. All the plans in D.C. essentially share responsibility for all of the EPSDT responsibilities.

ED HOWARD: And finally, how are immigrant children affected or covered by these important services, and what are states doing to ensure that the considerable number of children; that is to say immigrants are not left out?

SARA ROSENBAUM: Well it would be nice if they weren't. As a result of the changes to Medicaid – excuse me welfare reform changes enacted in 1996, which included changes in all the welfare programs including Medicaid, children who are recent arrivals into the U.S. meaning they are here within the first 5 years, I think, of arrival are not entitled anymore to any routine coverage even if they are eligible for it. They only get emergency care, and so one of the real tragedies of the '96 reforms was to essentially cut these children, cut new children off from preventive services at a time when probably they needed it more than anything. Now the state can, obviously step in with its own funds and provide routine and primary services and specialty services, but for newly arrived children they only get the same emergency coverage that undocumented children get. There have been for those of you who have been doing Medicaid for a while, there has been a repeated effort to try and eliminate this bar to full coverage

for pregnant women and children, and it has unfortunately, in my view, not happened.

CHRISTY FERGUSON: And I would just say that every state has a different way of approaching this. Some states have decided to provide 100 percent state funds and provide the same benefit package as Medicaid package, and other states have just stopped providing services to the population. And again, it gets back to the question of is it a healthcare program, is it a poverty program, what are you trying to accomplish as a state. And the difficulty is that when you are talking about cutting services to people who have been in the country for a long time versus people who have just entered the country, there is a tremendous political battle that is going on at the state level and within the legislature. And again, I want to emphasize, this is not republican versus democrat; this is literally across the board republican and democrat. There are really troubling and difficult questions that have to be answered at the state level, so as you look at what you want to accomplish with healthcare for children and families, the question that you have to ask is, what's the purpose of what we are trying to do with kids and families? And I would go back to an economic imperative that this country has to ensure that those kids that we are relying on to support us as a nation given the lower fertility rates and the smaller number of kids to larger numbers of elderly and working population, that we do

not have the luxury of saying there is some percentage of kids that we can do without because we can't as a nation. The demographics are such that we just can't. We don't have that luxury anymore, so we have to think about this, I think, from a different prospective.

ED HOWARD: Yes, you are at the microphone and I should say to paraphrase an old Johnny Carson tonight show routine, you hold in your hand the last question. [Laughter]

FEMALE SPEAKER: Okay. This is really for Christy. You seem to understand very well the long-term implications of children not getting treatment. Why is it then that so many other states are looking at the D and the T of – and state organizations are looking to cut the treatment as a way to save money in Medicaid?

CHRISTY FERGUSON: It's very simple. It's called at the end of the year you have to balance your budget. Literally. And so the way the states operate is they don't have the luxury often times of looking long term, and the whole political system at the federal level as well even though we can deficit spend on the federal side, the whole political system is set up on a short-term reward basis. So this is the same argument we have been having for the last 25 years; prevention versus immediacy is the question and immediacy almost always win. So we are looking at your Medicaid budget and you are trying to figure out what you are going to cut and

how you are going to cut it and what's going to give you the biggest savings in the shortest amount of time because you've got to do it within the course of 6 months sometimes. You've got to save that money. What you end up doing is either you cut reimbursement or you cut eligibility, I mean there just aren't – or you cut services. There just aren't a lot of options if you are thinking about it short term, and that's where the clash comes in. And the truth is that if the federal government had more of a clear picture of what its vision for kids and families was in terms of services, I think you would find a better partnership with the states because the states really do understand the relationship with education that this stuff has. But we haven't been able to really come up with that linkage because we are so set on fighting against each other, state and federal government, around loopholes and shenanigans and what's right and what's wrong as opposed to what are we tying to accomplish. And I think we are at that point now, and again, I am hoping that one of the things that will drive us there with kids and families is the demographics is sheer number of kids, lack of numbers of kids to support the country, and if we look at it from that prospective, we might be able to get beyond, you know, who's doing what to who.

FEMALE SPEAKER: So there might possibly be federal things that could be done to help the state after the short-term financial problems.

CHRISTY FERGUSON: Absolutely. Absolutely; particularly around kids. It's cheap. It's very cheap.

SARA ROSENBAUM: I actually take somewhat of a different view about why. Why this is such a controversy, you know, why does this remain a hot button issue. If you look at the per capita spending on children and the distribution of children in high cost cases, there's just – you could certainly knockout a few high cost cases by trimming the treatment requirements of the program and the diagnosis requirement, which of course, you would want to trim because you wouldn't want to diagnose a problem that then you weren't going to treat; so I think that there certainly is a cost issue. I think more than a lot of the other controversies around Medicaid with what we see here is a pure battle over the authority to design benefits. One of the great tensions right now in Medicaid is that for a lot of reasons having to do with whom the program serves. It's a program whose benefit design bears no resemblance to commercial insurance, and yet for families with children, we like to think of them as a commercial insurance market really, which to a great degree they are. And the problem is that among lower income children, there is a sizable proportion that doesn't fit neatly into the commercial box. They don't fit in at the front end because they need more front-end services than a commercial insurer typically covers, and they don't fit in at the back end when

they are very ill with a chronic condition. And EPSDT makes it difficult for states that want to do a lot of commercial insurance like purchasing through managed care. You got to think about this relationship between what the insurer is doing, what you are still responsible for, what you might buy in specialty care. I have always felt that the answer is not to blow up the benefit for children who have extra front-end needs and extra back end needs because in the end the state is stuck.

FEMALE SPEAKER: Right.

SARA ROSENBAUM: Just to give you an example; a state maintains what is known as a local parental relationship with its foster children. If you blow up the Medicaid program, the state now has to pay for all of the foster child's needs through state funding, if the foster care system doesn't have Medicaid. If you have extremely premature children, somebody is going to have to bear the healthcare costs of these children which can be quite extraordinary. So I think in my mind the answer has always been that once we have made a national decision to have a uniform benefit for children, which we do, unlike the rest of Medicaid for children, EPSDT is pretty uniform across states. There are differentials, but in broad strokes it's the same benefit. The federal government really ought to step in and make it a national funding issue as well. The state ought to get a preferred rate for paying for things

that go above and beyond a commercial insurance norm. In the case of elderly persons or persons who have Medicare and have disabilities, there is some more sharing of the burden because of Medicare financing; for children there is really nothing. I mean states remain totally responsible, so I have always felt that the way to deal with this is with a preferred federal rate.

ED HOWARD: Okay. Well those are some sobering and enlightening words on which to end this program. Let me just ask you one final time to take a moment and fill this blue form out. And also, I just want to take this chance to once again thank the Commonwealth Fund both for its helping to put this program together, and its support and co-sponsorship and Melinda Abrams and her colleagues have been wonderful in this regard. I want to thank you for sticking with a not very popular topic these days right to the very end, and ask you to join me in thanking our speakers both here and gone for what I think was a very enlightening discussion.

[Applause]

[END RECORDING]