

Ask the Experts: Medicaid April 20, 2005

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LARRY LEVITT: This is Larry Levitt from kaisernetwork.org. Welcome to Ask the Experts, our regular interactive web show that provides in-depth discussion of current health policy issues and allows you to interact directly with the nation's top policy experts.

Today, we're talking about Medicaid. To one of today's guests, it's the workhorse of our healthcare system, doing the jobs that other programs can't handle. To others, it's the pacman that's gobbling up state budgets. And in Washington right now, it's the issue in ongoing federal budget negotiations. At the biggest health insurance program in the country, strong views about Medicaid are not hard to find, and I'm sure we'll hear plenty more of them today.

First, some facts to help us put this debate in context: Medicaid provides health and long-term care coverage to 52 million Americans. 3 out of every 4 of these beneficiaries are low-income children and their parents, and the rest are persons with disabilities and the elderly.

Yet more than two-thirds of Medicaid spending goes toward nursing home care, drugs and other services for the elderly and the disabled. In fact, Medicaid paid for half of all nursing home care in the nation, and for nearly 1 in 5 healthcare dollars overall. Ask a state budget official about Medicaid though and you're likely to hear about how it's

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growing faster than state revenues and crowding out other needs. Medicaid costs are growing, but so is everything else in our healthcare system. In fact, on a per person basis, Medicaid expenses have increased less in recent years than private health spending.

So whether the current program is sustainable and affordable is not a question of fact, but rather one of values. Should we commit additional public resources to pay for Medicaid? Is the program largely on track or instead, in need of radical reform? These are precisely the questions we've assembled in an esteemed panel of guests to address by answering your question.

You can reach us in two ways - e-mail your questions to ask@kaisernetwork.org or call us here at the Kaiser Family Foundation broadcast studio and ask your question on the air. You can phone toll-free at 1-888-kaiser8. That's 1-888-524-7378. And we'll do our best to get to as many of you as we can.

Our guests comment this issue from a variety of perspectives and experiences. Jeanne Lambrew is an Associate Professor of Health Policy at George Washington University, and a Senior Fellow at the Center for American Progress. She previously served as a policy and budget official with the Clinton Administration. Alan Weil is Executive Director of the National Academy for State Health Policy and was a cabinet-

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level health official for the State of Colorado. And Jim Frogue is the Project Director at the Center for Health Transformation and previously worked with state legislators and is a congressional staffer. Thanks to all of you for joining us.

Jim Frogue, let's start with you. You recently wrote an op-ed in the Atlanta Journal-Constitution with former speaker Newt Gingrich. I'd argue that Medicaid has a series of difficulties and in fact may cause racial disparities in health outcomes. Give us a sense of your diagnosis of what's wrong with Medicaid.

JIM FROGUE: First of all thank you for having us today and thank you for putting that op-ed on your website, your daily bullets a couple week's ago, because it got a lot of exposure that way.

We think that that issue is one that deserves a lot more attention than it's getting. David Satcher in his article on health affairs - in the current addition, health affairs - said that racial disparities account for 83,000 extra deaths in the African American community if the healthcare received was the same as it was for Whites.

A couple years ago when the Institute of Medicine released their study that said medical errors caused a hundred thousand deaths a year that got a lot of attention. The racial health disparities are not. So we want to maximize this

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message; we want as many people hearing about it as possible; and we want to have a very thorough discussion with all interested parties.

LARRY LEVITT: And what's your sense in terms of Medicaid as a program? What do you see as the difficulties with the program today?

JIM FROGUE: Well there are a number of difficulties. I think that the program operates in a 1965 realm - government defined prices and government defined benefits. They wouldn't work in any other sector of the economy. And you suggested that to Governor Mark Warner, who was on your show last week for telecom, founder of Nextel. He certainly wouldn't have made millions if he had to deal with government defined benefits and prices in the telecom industry for cell phones.

So we think that actually inhibits innovation and experimentation in Medicaid. And we also think that governors need a lot more flexibility to deal with both their mandatory and optional populations of benefits so they can tailor those specifically to the needs of individuals. We think what Governor Bush is trying to do in Florida holds a lot of potential.

LARRY LEVITT: Alan, let me bring you in here with the National Academy of State Health Policy. You work with state policymakers, some of whom run Medicaid programs. What's your sense of what direction the program should be going in?

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ALAN WEIL: At the beginning of this year, we released a report that was the result of a year and a half of work with state policymakers and a number of representatives from outside of state government. And I'd say the summary of that report is that Medicaid is a program that's generally doing its job quite well. It probably is a great contributor to reducing the racial and ethnic disparities would exist if the program were not in place.

But it does need some improvements with time. It's actually a very dynamic program. It looks almost nothing like it did when it was enacted in 1965. But it does need to be brought up-to-date. The things that we focused on in our report were simplifying and broadening eligibility. After all, right now, there are large numbers of people in poverty who are not eligible for the program and they are largely uninsured. And it would be a better program, easier program to run if eligibility wasn't so complex.

We did talk about some flexibility around benefits and there's certainly some opportunity there to modernize the program. And we also focused on a piece that many people who talk about Medicaid don't spend enough time, which is the long-term care component. And there we, to make a very long and complex story short, focused on the notion of trying to tailor eligibility so that we could bring people the services they need before they reach the level of care where they may need,

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for example, nursing home services. So to catch people before their health status or their functioning deteriorates to the point of needing more acute services.

LARRY LEVITT: And how about - your governors are certainly focusing on the federal budget negotiations on the finances in the program. From a state perspective, how do they see the finances in Medicaid?

ALAN WEIL: We began the finance discussion by asking the question, "What's wrong with the current situation and what should be fixed?" And it was clear out of this discussion, that the general matching structure, the state-federal partnership, is one that largely works, but it does need some updating.

First of all, states feel like they could use more help. After all, the federal government can run deficits and states cannot. It has a broader tax base than states. We're moving into long-term care in other areas where demographic factors drive budgets and states can't be expected to carry those alone. So there is a sense of a need for a greater level of federal involvement and federal financing.

The area of dual eligibles, people eligible for both Medicaid and Medicare, is something that governors have been talking about for years that Medicare and the federal government is not picking up their share of the cost for a population that identifies the federal government as the source

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of their coverage.

So I think it's fair to say that states, particularly with the recent downturn, feel a need for a greater federal share and that fundamental principles of federalism, looking around the globe would suggest that a larger federal government role is appropriate when you're funding a program such as Medicaid.

LARRY LEVITT: Jeanne Lambrew, let me bring you in. And you worked on this program from a federal perspective, serving in OMB and have written about it since then. When you have conversations about Medicaid these days, you often hear words like "unsustainable", "unworkable". In your view, is this a program that is unsustainable?

JEANNE LAMBREW, PhD: I think that we have the wrong diagnosis for Medicaid. If you look at what the program does, it really is the ultimate infield utility player. It picks up where everybody else leaves off. And I'd argue it does so well.

We've seen in the last few years a retrenchment of private health insurance. Medicaid has grown as a response. Enrollment was up by 6 million since the year 2000, at the same time that the uninsured went up by 5 million. Without Medicaid, we would see more uninsured people because it's picking up the slack, where our health insurance system has dropped.

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It takes care of people with disabilities that private insurers really don't want. They do their best, through underwriting and other practices, to keep those people out. It's not a coincidence that Medicaid covers most people with HIV and AIDS. And it also fills in Medicare's gaps - 42% of benefit costs are attributable to the so-called dual eligibles - low-income seniors; people with disabilities who are both eligible for Medicaid and Medicare.

When you think about what it's done, it's done a good job at all those functions of pitching in where the system gaps have left people vulnerable. That said, what we need to do is try to figure out how to fix the system so that Medicaid isn't both blamed for kind of not doing a good job at what its trying to do and doing fairly well, and other actors and payers in the system pitch in.

I work at the Center for American Progress and we think that we need to commit to getting towards universal coverage as soon as possible. Medicaid is a key piece of that, picking up all the low-income people that it does now, expanding further up the income scale and really shoring up our existing private system. Medicaid is part of the solution, not really part of the problem.

LARRY LEVITT: And why? I mean in the proposal that the Center for American Progress released and you helped develop, you do build on Medicaid more. How did you come to

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that judgment that rather than retrenching, this program is actually one that should potentially expand?

JEANNE LAMBREW, PhD: I mean there are few very simple facts. One is the fact that most low-income people don't have enough income tax liability to really benefit from tax credits. Providing insurance directly to those individuals, rather than the bank shot of trying to give them a tax credit to get insurance, is a more direct, efficient way to go.

Second, we know Medicaid is an efficient program. Sometimes states would argue too efficient or providers would argue too efficient in terms of how much you pay as providers. But it is a very affordable way to go in terms of trying to figure out how you cover those individuals.

And third of all, we have 50 state programs. It exists. We don't have to go out and create new bureaucracy if we wipe away Medicaid and try to start from scratch. We think it's done a good job. We think it's a great place to start and it's a good program to get low-income folks in.

LARRY LEVITT: We've laid a good basis for discussion and we've gotten no shortage of e-mails on this topic. Let's go straight to the questions from viewers.

This first is from a reporter in Washington - that I think gets to the heart of the issue, and I'll read a bit of it. "The governors and the Administration both agree on giving states greater flexibility in providing Medicaid benefits, on

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the grounds that some relatively better off beneficiaries don't need the same comprehensive services that the most vulnerable mandatory beneficiaries do. But are there really large numbers of better off beneficiaries actually using services they don't need, which would seem to be the only way the greater flexibility could actually free up resources to cut state and federal budgets or expand coverage?"

Jim, let me come back to you - and you talked about the need for greater flexibility on the part of state Medicaid programs. What's your reaction to this?

JIM FROGUE: Well I think that's right. I think it's important to make sure that Medicaid is focused on what its mission is, which is to finance healthcare for low-income people. And it's not doing a good job of that.

Medicaid is the lowest reimbursor in the system consistently, in any state, lower than Medicare, lower than private insurance. And you have to ask, does that attract or does it repel providers? And providers are withdrawing from Medicaid and I think that's very important. You don't have a healthcare system if you don't have providers participating in it.

One thing that Jeanne said about tax credits, I think, has to be corrected a bit. And that's that every tax credit that I've seen for the uninsured is fully refundable. So income tax liability doesn't matter. If you're eligible for

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the credit, you get the full amount of the credit, whether or not you owe any federal income taxes.

When I worked for Congresswoman Kay Granger, we had a tax bill that did that - it was fully refundable. Every credit I've seen is fully refundable.

The questioner actually laid his finger on an important point, which is whether or not people are using Medicaid services who shouldn't be. And I would strongly encourage anyone to not take our word for it, but to take less than a second to Google "Medicaid Estate Planning" and get the thousands and thousands of hits you get for people - lawyers and lobbyists and consultants - who teach people how to hide their assets to qualify for Medicaid.

Now, we have to ask ourselves the very difficult question, is Medicaid retirement insurance for the middle class? I don't think it should be that way. Governor Warner last week talked about this issue I thought very courageously. He used the word "aghast" three times to describe what he expects to get from his democratic base because he even brought up this issue. But I think he's absolutely right. If you have people utilizing Medicaid services that should not be, that necessarily takes dollars away from people who are poor and do need the services.

LARRY LEVITT: So you would support President Bush's proposed tightening up on the ability of the elderly to

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transfer assets and gain eligibility for Medicaid nursing home coverage and you would support moving in that direction?

JIM FROGUE: Right, absolutely. And I know the Governor Association is looking at doing that too, encouraging reverse mortgages and home equity. Most people, especially in this town, would probably take an income of \$1,200 a month if they could also live in a paid-off house. You know, we have to think of wealth beyond just income, but whether or not it includes home equity as well. Most seniors live in their own homes and most of them live in paid-off houses. Their income may be \$1,000 a month, but there's equity there.

And again, that's just a policy question we have to be up front about. Is Medicaid retirement insurance for the middle and upper classes with fancy estate lawyers? Maybe it is. But let's be up front about that debate and have it in the open.

LARRY LEVITT: Well we've got lots of questions on that topic, so let's stay on that for a moment. Jeanne, from a budgetary perspective, is there a sense that there is a lot of this transfer of assets going on and if there's real money here?

JEANNE LAMBREW, PhD: Well, if you - don't ask me, ask the Congressional Budget Office and the current OMB officials' office management budget officials. And they find that there are just about a billion or two billion over a 5-year window

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that could be recaptured in this way.

I want to contrast that though with the \$290 billion in estate tax relief that we're going to give the high-income people. We're talking about trying to recapture among middle class people because we really have no ramping evidence that there is a serious estate planning - there may be people on the website trying to sell the services - we don't have a lot of evidence that a lot of people are using them and using them effectively to get into the Medicaid program. It's just more of a myth than a fact.

And in that vein, I'd like to go back to these two issues that came up. One, about reimbursement - there are anecdotes about providers not participating in Medicaid, but the solution doesn't make sense, to say that we're going to fix low reimbursement by cutting Medicaid just doesn't make sense on the face of it. We need to increase federal Medicaid financing so we can really ensure that there is affordable access across the country.

In addition, going back to this racial disparities issue, I have to tell you Jim, I'm going to use your article in my class this fall as an example of what we call, "ecological fallacy," saying that there's a relationship between two different aggregate phenomenon in it's causal. The idea that Medicaid causes racial disparities is just not supported by the evidence.

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LARRY LEVITT: I want to bring out another nursing question, but Jim, let me give you a chance to respond as well. Did you suggest in the article that Medicaid is a contributing factor in racial disparities?

JIM FROGUE: Yeah, but we were very clear to say it's certainly not the sole cause and we would never make that connection. But something Alan said earlier about Medicaid helping racial disparities - well actually it hasn't helped. David Satcher's article said that from 1960 to the year 2000, racial disparities, in contrast to income and to housing and to civil rights, racial disparities had actually stayed the same and in some cases, even gotten worse.

Now Medicaid came around in 1965. It is disproportionately minority. We have to ask, at the very least, whether or not it's living up to its potential to cure racial health disparities - to cure that. And I'd argue pretty strongly that it hasn't. And there are a lot of things that governors can do if they had more flexibility that might be able to make some dents in that very serious problem.

And I am glad that Jeanne wants to show it to her class. I hope as many people as possible read this article and begin talking about this issue because it is uncomfortable. But it is something we absolutely have to discuss.

LARRY LEVITT: Let me ask you - and the question that started all this was about giving governors flexibility - Jim,

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giving to mind some specific examples of what kind of flexibility you think would help give governors the tools to maybe improve Medicaid and potentially reduce disparities?

JIM FROGUE: Well sure. I think one thing that some governors have asked for is complete flexibility. Now, I don't think the federal government's ever going to write them a check and say, "Good luck. Go serve some healthcare."

But I do think that if a few governors would like to be cut loose from the current program and accept a defined contribution from the federal government in exchange for more flexibility, if the money they received was lower than projected trends where the federal government would actually save money, and in exchange for that, the state would get all the flexibility they want and then the feds could set up metrics to measure diabetes, physicians in rural areas, all different kinds of things like that, and actually have it be results-oriented as opposed to process based. I think you'd have a lot more potential for improving the delivery of care.

Again, for people who may be watching this and don't know who's right, ask your own physician whether or not they take Medicaid. Ask he or she if they accept Medicaid patients. Ask them what they think of the program. And ask them if they'd like to see more of the middle class in Medicaid. In any state, ask them. See what they say. Then you'll get an honest answer.

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LARRY LEVITT: Alan, you ran a Medicaid program in Colorado. What's your view? Did you feel hampered by federal regulations? Specifically, what types of flexibility would you have been looking for as a state official when you were running Medicaid?

ALAN WEIL: I think we have to be very careful about what we mean when we talk about flexibility. When we convened a group of folks from the state, we came up with some fairly concrete examples of places where states felt flexibility might be helpful.

And I should say that this process was designed to come up with one unified set of recommendations. So when I talk about the flexibility, it was also in conjunction with expanding coverage to everyone below poverty.

But with that said, there was a sense that as you move higher up the income scale - particularly the limitations on cost sharing that are very tight in the Medicaid program - might be loosened for that population. I know not everyone thinks that's a good idea, and I think it's hard to figure out exactly where to put those lines, but in terms of a sense of a place where, as you're thinking about the program growing and responding to what's happening and the changing population it's serving, some flexibility there would make sense.

The notion that sort of flexibility by itself saves money is something that state people who've run this program

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have never really been able to make much sense out of. Flexibility certainly could be to just cut benefits. And if that's what you want to do, again, we ought to just say that what we're looking to do is to cut benefits.

But I have to say the notion of sort of converting the program into a defined contribution to the state sounds to me very much like...

JIM FROGUE: Like a block grant.

ALAN WEIL: I won't even call it a block grant, just something where the federal government says, "Here, you do the best you can" sounds a lot to me like experimenting on the backs of the poorest and the most vulnerable people. And it's nice to talk about performance standards, but look at how little progress we've made in the private sector, where there's a lot more money floating around in terms of holding providers and physicians accountable for performance. There are a lot of other factors in whether or not people are doing well or poorly.

Why do people on Medicaid where racial and ethnic minorities are disproportionately represented do less well on various health measures? Number one, they're poorer and we know that there's a high correlation between poverty and health status, as well as between poverty and use of the healthcare system. So this notion of sort of loading everything onto the healthcare system and saying, "We're going to hold you

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accountable," it sounds really good, but we don't know how to do that very well.

And to just go wholesale from saying everything that we look at now with respect to rules and process, we're going to throw out the window and we're just going to say, "Well, outcomes are all that matter," that would make a lot more sense in a world where we felt more comfortable about outcomes.

I just need to take a moment though because we got into this notion of asset transfers and the like. Another thing that I think is a little difficult in the debate right now about Medicaid is, on the one hand, I hear a lot of criticism of the program. It doesn't meet people's needs. It doesn't pay providers. Providers don't want to participate in the program. And then I hear people are going out of their way - wealthy people are going out of their way to get on this program. Well I don't get it. If you have enough money to afford care, why would you go into a system that's so terrible? The fact is, we don't have, as Jeanne said, much evidence that this goes on, although we do have evidence that people try to do estate planning.

And I think it's important to differentiate estate planning, which is sort of a legal technique to try to hide assets from the broader, social question of whether or not the cost of going into a nursing home, if you're a middle class person, should fall on you as an individual or should be spread

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across other people in society. And frankly, I don't have any problem personally answering that question.

Whether you end up in a nursing home or not is a bit of a lottery. And the notion that every middle class American should pay 100% of the burden of losing that lottery, I don't think that's the kind of society most people want to live in.

LARRY LEVITT: I think we had a question asking whether Medicare should instead cover long-term care rather than loading this onto the Medicaid program. Is that something that you think would make sense?

ALAN WEIL: Well, I think states have - as I've talked to them - have very mixed feelings about it. On the one hand, fiscally transferring the burden of long-term care to the federal government would be a great relief. But as a practical matter, long-term care and the delivery of long-term care services is very local and it's very community based and family based and service based. And I think a lot of states have concerns about whether or not the federal government is the right level to organize those services. But certainly if they took the responsibility and the financing responsibility, states would make out quite well.

LARRY LEVITT: I'm sure we could talk about each of these questions for the entire hour, but we do have other questions. And we've got a caller from North Carolina who's been waiting very patiently. Caller, if you're there, please

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go ahead.

FEMALE SPEAKER: My question deals with co-payments and particularly co-payments from parents of disabled children who may have relatively higher incomes and could afford co-payments. And I'm just wondering what states could do to get more of a cost share from that group of people?

LARRY LEVITT: Alan, let me start with you and then go to Jim and Jeanne. You talked about potentially some room for co-payments for - I don't want to call them higher income beneficiaries - but maybe higher low-income beneficiaries.

ALAN WEIL: Right. I mean I think it is important to think about our language here. You know, when you're in Washington, you talk about Medicaid, you talk about 133% of poverty and 200% of poverty and things like that. We are talking about people who are generally - and families that are making \$15,000-20,000 a year and when states do major expansions, they can certainly go up into the \$30,000 and \$40,000 range, which, depending on where you live, may give you a little bit of pocket money.

We also need to keep in mind that there are very different children served in this program. Some of them are severely disabled. And if you impose a \$3.00 or \$5.00 or \$10.00 per service cost share, particularly on something like a therapy or a prescription that you might have to fill multiple ones of in any given month, what sounds like a small amount of

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money to me or to someone who has sort of typical healthcare needs, could end up to be a lot.

That said, I do think states do feel that as they move up the income ladder, that they ought to be able to charge a little bit more in terms of cost sharing. I'm not sure however, given that you'd want to protect the most vulnerable kids - those with the most needs - that you end up saving a lot of money. And in fact, there is some evidence that you end up, depending on how you apply those cost sharing provisions, hurting people's health, which they're just going to come back into the system and need more services.

So I'm afraid the evidence doesn't really support this as a very effective either health management or budget management provision, but from a social perspective of asking families to participate in the cost of a service when they're not living in poverty, it's something that speaks to people and I think we need to balance those two out.

LARRY LEVITT: Jim, you talked about higher cost sharing in general being a sensible approach in the healthcare system. Do you think that's something that also applies to Medicaid?

JIM FROGUE: Yeah and I think Alan touched on something that's absolutely right. People who may not be right at the poverty level and have a little bit more money should participate more in the financing of their healthcare, be it

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with their own dollars or dollars given to them by the state Medicaid program.

I think it's wrong for anyone - I'm certainly not suggesting anyone here - but it's certainly wrong to ever have the assumption that people on Medicaid are too stupid to look out for their own healthcare. The cash and counseling demonstration model, which has been in existence in 3 states and now there's over a dozen, have a waiver into it, deals partly with this problem we're talking about for development and disabled.

It's extremely popular in the disabled community. Because what it does, it's essentially a health savings account for people who have development and disabled adults or children who have a caretaker, or they themselves can participate in the financing. And what it allows is for the purchase of home care services, which is a narrow range of services. But it does allow people to have control over their own dollars. Providers who participate in the program and serve these beneficiaries, the checks they receive, the name for the beneficiary is actually on them. And that really changes that dynamic. You don't work for the state, you work for me, the beneficiary, and helps treat people with the dignity that they deserve.

This program's been around for several years now, starting back in the late 90s and it has higher satisfaction rates, satisfaction rates almost at 100%, people are getting

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more care of better quality and they're very happy with it, and there's beginning to mount some evidence it actually keeps people out of higher cost institutions down the road. But most important of all, it treats people with the dignity they deserve that they're not too stupid and they don't have to wait around for whatever service provider the state hires, they can actually get a budget and make decisions about their own care.

I think that's a very good model. It's only a few thousand people in a few states at this point, but it does prove that people on Medicaid, many of them are absolutely capable of participating in their own healthcare financing. And this is something we've been strongly encouraging now for a couple of years.

ALAN WEIL: I think it's important to say something about cash and counseling because it's an example used by many people about the direction this program ought to go. And there are two points that I want to clarify. First of all, this is a very narrow demonstration about predictable regular monthly costs that people incur for a very narrowly defined set of services.

And the notion it is of course the case that people can manage their own care with family and community supports, they can deal with the tax implications and all sorts of things, but it is a very long distance from there to giving someone an amount of money to go out and buy an insurance product or to

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bear the risk for hospital care or even pharmacy care. These are completely routine in the sense of predictable needs that people have. And to transfer that from a state controlled system to an individual controlled system does seem to be making some real progress.

The second important point about cash and counseling is it's not about people bearing financial risk for services. It's about managing a budget, which is very important, but it's not about saying, "You've got skin in this game and so you're going to gather all this information and make wise decisions." The state is still the funder of the services. So there are a lot of great advocates of cash and counseling out there, but I think we need to remember what we've learned from it and what it isn't also.

JEANNE LAMBREW, PhD: If I could just add. I mean in terms of also trying to keep our extensions of our policies narrowly constrained, when Alan was talking about flexibility with regard to cost sharing, I think there is a general agreement that the higher up the income scale you go, the more you can do that.

But let's go back to the reality of Medicaid. The reality of Medicaid is that we have very few states that cover adults up to the poverty level. There are most states, including Texas, for example, that only cover parents up to about 17% of the poverty level.

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JIM FROGUE: What is that, in dollar terms?

JEANNE LAMBREW, PhD: If you look about 50% of poverty level, that's about \$154 a week, to give that perspective. If you look at a single person, if you work full-time, minimum wage salary, that's about equal to the poverty level. So we're talking about people who are just not fully members of the workforce. These are people with very low income.

And to talk about cost sharing for this population, in terms of having them pay for their services, we have evidence that people faced with cost sharing when they have limited means, will not use needed services. A family with a disabled child may not get the services the child needs and may end up in [inaudible] in a more expensive way. So I think we really need to parse our terms carefully.

Cash and counseling is for a narrow set of services in a very discreet set of people. Cost sharing, I think, even in Alan's report is talking about higher income people, not the majority of people on Medicaid who are not children who are very low income.

LARRY LEVITT: As I said, I'm sure we could talk about each of these questions for the full hour, but we do have another caller waiting patiently on the line from Colorado. Please go ahead.

MALE SPEAKER: My question is, how far can states go in restructuring their Medicaid programs without federal waivers,

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or what have you, to constrain their budgets? It seems like they are fairly constrained by federal laws and so forth, but how much can they cut from their Medicaid programs to accommodate their budget problems?

LARRY LEVITT: Great question. Thank you. Alan, let me start with you. You did run one of these programs and work with state policymakers quite regularly. Give a sense of what kind of flexibility - we're talking about what kind of flexibility governors may want. What kind of flexibility do they actually have now to make changes in the program?

ALAN WEIL: Well the question is important because it raises two things. One is flexibility to restructure, which was the caller's question, and also flexibility to constrain within budgets. And those aren't always the same thing.

So since I know a little bit about the Colorado Medicaid program, I can say that it's a state that runs a program with very few options. The way the Medicaid program is designed, there is a federal minimum with respect to who you cover and what you cover. And you can't go below that. Now, you have a fair amount of control over how much you pay for services, so you can take this out, you can control your budgets on the backs of the providers.

LARRY LEVITT: So how much of your doctors and hospitals.

ALAN WEIL: Exactly. And when you cut the payments,

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you run into access difficulties, as Jim mentioned. If you're already running a program that's fairly close to the minimum, in terms of who you have to cover and what services, you don't have a lot of room. But every state has some options, and Colorado certainly does. And you, in tight budget times, look to those and consider scaling them back if that's what you need to do to save money.

But then there's the question of restructuring - and I don't know what the caller had in mind. You can't fundamentally restructure the Medicaid program without a federal waiver. You have to define a population that you'll cover. You have to define the services that you'll cover. You can use managed care and different delivery systems. Some of them require waivers and some don't, but those aren't very hard waivers to get. And you run a program like that without a waiver.

If you want to go more broadly to something like what Oregon pursued many years ago with setting priorities of what services you'll cover; if you want to approach it the way Florida is discussing now, where you give people sort of a cash grant and they go buy whatever coverage they can afford with that and the state doesn't guarantee the coverage; if you want to fundamentally eliminate certain benefits in the program, you can't do that now without a waiver.

LARRY LEVITT: And we started to talk about waivers and

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we had an e-mail question about these waivers. The Secretary of HHS - and correct me if I'm wrong - has fairly broad authority to grant waivers to change the Medicaid partner - for states to change the Medicaid program.

The e-mail question we got was about what evidence is there that these waivers have improved - the program, improved health outcomes. Jim, is that something you've look at, that some of these waivers that are out there now to restructure the program, some in the direction you've talked about? What's been the result of these?

JIM FROGUE: Well, sure, the Independence Plus waiver is one we just discussed. And that's the one that allows for the cash and counseling experiments. And they've been very successful and there's a huge waiting list to get on that program among the disabled community down in Florida and other places. It's very popular.

I think one of the things we talked about a minute ago was the waiver process, even now, with a President who's granted, to my understanding, is more waivers than every other President combined. We have Mark McClellan, CMS, who is, in my judgment, the best CMS director that there's ever been. Even then, they're swimming upstream against tides and tides of regulations that are very difficult.

One of the thoughts that we've been considering is whether or not, again, governors might choose a defined

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contribution from the federal government and then just have complete authority over their own Medicaid program, so they wouldn't even have to ask for waivers. Governors are more accountable to their citizens than anyone in Washington, DC. That's why they're governor. That's why they get elected. That's why they stand for reelection. Governors are the most accountable. They should have maximum amount of authority and not have to come on bended knee to Washington, DC to ask for waivers.

LARRY LEVITT: In my experience, members of Congress typically don't like to let money out the door with some accountability or ability to monitor it. And you talked earlier about being able to monitor the outcomes of programs like this. Give us some sense of what kind of outcomes you would look at for state Medicaid programs if governors did have this total flexibility.

JIM FROGUE: One of the ways that Governor Bush in Florida suggested is perhaps look at the disease groups that account for most of the cost - diabetes, congestive heart failure, asthma, things like this - and take metrics. Florida has a huge database of information. They have incredible amounts of information. That's why not every state can do this. But they're actually able to risk adjust premiums. So if they get this waiver and go ahead with the experiment that they're considering, they can have a risk adjusted lump sum to

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every Medicaid beneficiary.

Now, this opens up the system to a lot more competition, to a lot more providers, and it gives the patient a lot more control. This is a big shakeup of the Medicaid program if this ends up in place. And we'll see. It's the most radical restructuring of Medicaid, in my judgment, it will be successful, but let's see. Welfare reform happened because a few governors tried it and were successful. Governors should be given the maximum amount of flexibility to make these decisions. They're the ones that are most accountable.

And if 45 governors say, "This was the craziest idea they've ever heard of, now I want the match rate," that's fine. But if 4 or 5 think they might want to try this and they tell the federal government, "We're going to improve outcomes and we're going to take less money," let them give it a try. Hold them accountable for outcomes. Let them do it. The governor is more accountable to his citizens than anyone in Washington, DC. Let him have that option.

LARRY LEVITT: Jeanne, give a sense - I imagine you reviewed some of these waivers when you were at OMB. Give us, from a federal perspective, looking at some of these proposals that come from governors. What are the challenges in looking at these waivers? What are the challenges in monitoring outcomes of them?

JEANNE LAMBREW, PhD: Sure. I would say that if you

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look at any federal authority that the Administration has, the waiver authority in Medicaid may be the largest. Because in terms of dollars, billions and billions and dollars already flow through these waivers. So I think there is kind of the question of, is Medicaid rigid?

I think Alan, when he started, talked about the fact that it really has adapted and grown over the years, through both law, through state flexibility and through waivers, it really has. In terms of though this idea of experimentation, when I was in the Administration, we took it very seriously because, as Alan said, you are talking about the most vulnerable people.

I mean the risk of putting a person with disabilities into a kind of risk-adjusted voucher is enormous. Because if the providers aren't there, if the services aren't delivered, that person may have lost their lifeline to services.

And I just want to get back to this issue, which is - why are we doing this? What is the goal of this restructuring? The caller asked about money. That was the presumption. The presumption is Medicaid is spending too much, it's out of control, we need to figure out the money problem. The reality is the healthcare system is expensive, not just Medicaid. People with diabetes and these other conditions are taking drugs. Their cost growth has gone up at double digits every single year. Why governors, with a capped, slowed rate of

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growth are going to be able to solve the healthcare cost problems better, is something that is I think a question - a very important and open question.

LARRY LEVITT: And healthcare cost [interposing] being the whole healthcare system. No, it's really just Medicaid. We do have another caller on the line from Maryland. Please go ahead.

FEMALE SPEAKER: Hi. It's wonderful to hear you all and I think it's just terrific that you're talking about racial diversity and economic diversity and healthcare services. However, I note that often the policymakers do not reflect the diversity of consumers that are being served in Medicaid, both in disability or color or money, and just look at the present panel, for example. Can you all comment on how to bring in more stakeholders into the process so you design a system that really gets to their needs?

LARRY LEVITT: It's a good point. We appreciate your helpful criticism as well. Alan.

ALAN WEIL: You know, one of the things we do in my organization, we provide the infrastructure for a meeting that CMS holds on some of the systems' reform and it's a very large meeting, and it is filled with people who represent the true participants in the Medicaid program, particularly in the area of disability. It may be somewhat less so racially and ethnically, but certainly people with disabilities are very

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much involved in the kinds of reforms that have gone on.

And I thin the caller is absolutely right that particularly in Washington, where you sort of filter things through other people and who ends up being the ones at the end of the filter tends to be a more halogeneous crowd. I think it's fair to say, particularly in many states, perhaps not all, that you have more organized presence of recipients. You have, under federal law, you have to have a number of advisory commissions that generally have to include - and even if they don't, they would include - consumers in the program. It's a common and constant issue to pay attention to.

I think when you lose sight of it, you fall back into more homogeneity, but there are concrete efforts around to try to offset that and remind us all the time of who needs to be in these conversations.

LARRY LEVITT: And you talked earlier about the healthcare nursing home care and that example being a very local phenomenon. Is this, and the diversity issues is an argument for keeping states in an active role in managing these programs?

ALAN WEIL: Yeah, as much as states worry about, and complaint about, Medicaid budgets, it's hard for me to find people who think that the answer here is to just have states wash their hands of the responsibilities in these programs. And since I didn't get a chance to say it, I really have to ask

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a question about the notion of sort of handing it over to the states and holding them accountable for the metrics, which is I don't know what happens next.

If the state does poorly, what does the federal government do? Do they take away the money because you did a lousy job? Then you're going to punish the recipients of the benefits for potentially the corruption or the lack of - or maybe it was just a flawed model. Maybe it was a great idea that didn't work in practice. Or if they do well, is the federal government going to say, "You're doing so well, we're going to give you more money and reward you"? There aren't a lot of examples of that happening.

So I think the role that states need to play is one - and that they do play in the program - is that they can bring together the interest and they can tailor programs, but there is a limit to how you can structure a performance-based relationship between the states and the federal government.

LARRY LEVITT: Jim, let me ask you. It has always been a challenge of federal enforcement of programs like Medicaid, where it's difficult to resort to the nuclear option of just taking away state money and what good would that do anyway? And I think that's a challenge no matter what the structure of the Medicaid program is. In an outcomes-based system, like you laid out, what would the enforcement mean? What would the federal government's role be in monitoring and then enforcing

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these kinds of outcomes?

JIM FROGUE: I thin Alan made a very good point, that states are more reflective of their local constituencies in the federal government. The caller's question I thought was a very good one and I was kind of chuckling as she asked it. She's absolutely right. Why should senators from Vermont, which is 98% White, affect policies in Mississippi, which is 40% African American? People in Mississippi, people in Louisiana, people in Alabama, would probably have far different solutions and involve more local providers than other states. That's why that kind of flexibility is important.

Among the many things that contribute to racial health disparities, Medicaid I've suggested might be one of the many. One of them is African Americans, and others, may not be as comfortable going to doctors and physicians and provider who are not also African American. That's why it's so important to increase the number of providers in minority communities so that access improves. And that's a big part of the solution.

LARRY LEVITT: Well do you think we might be able to do that?

JIM FROGUE: Well I think there's a wide range of things we can do. But I think it's something that's very important. I mean one of the things - we can encourage more minorities to go to medical school. We can encourage more to participate in this process. Not to criticize you, but perhaps

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you could get more diversity than us three White people here. And that might be an advantage.

But I think local constituencies, state government, is going to be far more reflective of the local atmosphere than Washington, DC. And that's why it's so important that states have more authority to make these decisions, so it does reflect their local needs.

JEANNE LAMBREW, PhD: I'll come back to this issue about what are the relative roles of the federal government, state governments and local governments? Because we have seen local delivery system innovations that are quite important. I think when you are dealing with, especially the disabled, population, you really do need to be on the ground to do that.

But why shouldn't a senator from Vermont hear about whether a poor child has insurance in Mississippi? Why do we here in Washington care about national security in California? Why do we think all children should have education no matter where they live? There is this fundamental question - and I think that we may disagree on this - that all people who are vulnerable, irrespective of where they live, should have the same access to our high-quality healthcare system, no matter what their race, no matter what their income, no matter where they live.

And if we're going to really define ourselves as a nation that is compassionate and value-based, I'd argue that

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there should be a say that all of our senators have in eligibility and coverage. Are we really going to, as a nation, provide for our most vulnerable citizens these essential healthcare services? And I don't think that should be devolved to the states. I don't think we need more flexibility in that area. In other words, I think we need a more federal role in ensuring those protections and, as a result, more federal money to make sure it can happen.

LARRY LEVITT: And Jeanne, the Center for American Progress laid out a proposal with federal minimums and guarantees, which in many ways, moves in the opposite direction.

JEANNE LAMBREW, PhD: Correct. The opposite direction from the state flexibility that is about flexibility and eligibility. We really think that we should come to some agreement as a nation about what we want to do about our low-income, as well as all of our citizens having access to healthcare.

LARRY LEVITT: It's hard to talk about state flexibility and federal enforcement without talking about accounting loopholes, gimmicks, intergovernmental transfers - and we got a number of e-mail questions about that.

Jeanne, as the former federal budget official here, if you could just lay out very quickly what is at issue here. What are these intergovernmental transfers? What are the

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accounting gimmicks that people are talking about?

JEANNE LAMBREW, PhD: Sure. There's just two sides of this. There's what Medicaid pays and where the states come up with the funding for this. Medicaid has actually granted states a considerable amount of flexibility in how they set their provider payment rates. And as a result, some states over the years, in various programs, the disproportionate hospital share program, through upper payment limits, have set payment rates to public providers at a higher level in order to access a higher federal payment, which could then be used to either finance Medicaid or other services in the states.

The intergovernmental transfer happens when that public facility that's getting the higher payment rate usually has a county appropriation or a state appropriation, and that money is being used as part of the payment scheme to kind of generate what are so-called excess federal funding.

I worked on this at Office of Management and Budget in clamping down on disproportionate share hospital payments. We did the regulations on upper payment limits. And the Administration frankly has tools at its disposal without Congress to begin to look at this more.

That said, I think we have to do this carefully. At a time when we have had a recession recently, where states have been trying to sustain what has been a major increase in their enrollment due to a failure of federal policy to really address

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the uninsured, do we want to, at this time, go cold turkey and pull away these payment policies that are legal and that Congress has let go on, but is all of a sudden saying, "We're not going to do it"? I think that we do need to have a fiscally strong program that's high in integrity, but we also need to do this cautiously because the people who may be hurt are beneficiaries.

LARRY LEVITT: And the Administration does have tools and in fact, they've put out what some people have called a hit list of states. Alan, give a sense - is this widespread? Is almost every state doing this? Is it concentrated on just a handful of states? Is it a key part of financing and state budgets in state Medicaid programs?

ALAN WEIL: There are some states that have been more creative and aggressive in terms of trying to maximize the federal dollars they bring in. There are some that have barely dabbled in this game and there are some that maybe came a little later after some of the clamps were put on it and so they couldn't go as far as the other states. That's sort of loosely how I would describe it.

You know, I think states want a fiscal partnership with the federal government with rules that they can follow. It is certainly the case that just like a wealthy person who hires a tax accountant to figure out how to minimize their tax burden, within the constraints of the law, states will try to figure

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out, within the constraints of the law, if they choose to do so, how to maximize the number of federal dollars they can bring in.

And if the rules change, the rules change and the states will adjust. They probably should be given a little time to adjust if the rule changes are huge, but they shouldn't be told retroactively that something that we told you was okay a year or two ago, because it is now not acceptable and we're going to take all the money back from the last few years, which is something that states are confronting.

And states shouldn't be told, "We're going to have someone looking over your shoulder for every transaction and make it impossible for you to run your programs." That's the antifascist of the kind of flexibility states want.

This is not a small issue. But I want to emphasize this is a solvable issue. We have 55 jurisdictions that run Medicaid programs. Their accounts are open. There is the OIG. There is GAO. There are plenty of people who can come up with rules. This is kind of like a state recovery.

It's really fun to talk about it because it sounds so egregious, but once you go after it, you start realizing that there are real people on the other end whose situations are pretty sympathetic. And the same thing with states - there are some egregious examples that it's kind of fun as the poster children, but mostly this is states trying to preserve their

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investment in healthcare through difficult fiscal times.

So we can keep talking about it all we want, but it's a lot easier to talk about than to do because the consequences are not minor. If we could come up with a good set of rules for the road, which I don't think would be all that hard to develop we could enforce them. But some members of Congress get a little skittish when they realize that the rules they want to clamp down on are rules that are benefiting their own state.

LARRY LEVITT: So that senator from Vermont or wherever starts to get quite interested. Jim, I saw you nodding your head a bit. Is this one that we actually all agree on?

JIM FROGUE: Well yeah. And I think this issue is one that's been going on for decades and will continue to go on for decades, so long as there's this federal match. States are rewarded for coming up with these kinds of things. And when they're caught, they don't really get in trouble. So there's a very strong incentive on behalf of the states to be very creative with these kinds of accounting gimmicks. And the GAO has a great chart where they show that every couple of years, Congress has to come in and clamp down. And this has been going back through the 80s.

I'm sure if we sit here in 5 years, hopefully a little more diverse panel, we'll be talking about the latest scheme that came up in 2006 or 2007 that we couldn't possibly have

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imagined sitting here right now. But there's a way to make this go away. And the way to make this go away is shine a big spotlight on how much a state gets each year through a defined contribution.

If everybody knows - democrats, republicans, governors, legislators - how much Louisiana or Colorado, when you say, is getting at the beginning of a year, you have millions of accountants watching this, not the few that the federal government is watching. So this is an issue. We could probably debate all day about how much of an issue it is, but I think we all agree it is an issue.

But let's make it go away so Medicaid directors don't have to spend too much time coming up with creative accounting techniques and more time actually making people well. Because one of the things - and Medicaid's biggest problem - it doesn't serve people as well as it could. Let's spend more time focusing on that, as opposed to coming up with accounting schemes and sitting down applying for endless waivers from the federal government. It would be easier if states had a lump sum, they could make these decisions, and back to Jeanne's point earlier, we disagree on this. I think accountability is best when it's local. Local accountability is always better than accountability that's thousands or hundred of miles away.

If we can have a governor and a state legislator running this program, then anyone who has an issue with it,

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they can't blame Washington. They just blame their state capitol, their local representative. And they vote them out if they screw it up. That's the kind of accountability we want to see.

LARRY LEVITT: We only have a few minutes left. But we certainly got plenty of questions about this issue as well - the idea of a defined contribution, a block grant, a lump sum payment.

Jim, you certainly made a strong case for that. The last time this was proposed and debated, governors argued that they were concerned that in a recession, a lump sum - the advantage of a matching payment is it adjusts over time with economic circumstances. A lump sum potentially doesn't do that. What would you say to governors who have that concern about the effect of economic cycles?

JIM FROGUE: I would say, consistent with our view, that more choice is always better. If 45 governors think this is a crazy idea, nothing changes for them. We don't want to force this on anyone.

LARRY LEVITT: Do you think this is an option?

JIM FROGUE: Yeah, an option. If 3 governors want to do this and another 47 think they're crazy, then fine. Let the other states run it the way they want and let the states who are willing to take this risk and shoulder this responsibility and be accountable local. Let them have that power.

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I think it's an incredible arrogance to say they shouldn't have it if they want it. And then the federal government should audit outcomes as opposed to the overseeing of process, which is what they do now.

LARRY LEVITT: Jeanne, what's wrong with giving a governor the option of running the program as is or moving to more of a defined contribution?

JEANNE LAMBREW, PhD: It's an interesting example. Because we have so much debate about these block grants and caps on federal funding that we don't have a lot of evidence to back it up. So I did a study where I went back and looked at Congressman Gingrich's proposal. And what he proposed as the federal cap between 1996 and the year 2002, and compare it to what actually happened. And it's actually very interesting because in the first few years, the federal funding was higher than actual spending. In other words, governors did better than what the Congress anticipated they would do. So there was more federal funding than was actually spent.

But by the year 2002, there was a recession. And so what had happened was by then, there would have been a \$23 billion shortfall in federal funding for the year 2002. So the question becomes, in that case, a governor could have chosen in 1995 and said, "Sure, I'll take this deal. It's a good deal for me." The next couple years - and I'm a term-limited governor - I'm accountable, I have extra money, I can do all

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sorts of interesting things.

But what would have happened in 2002 had that governor, who then would have left, the new governor is in place and there's 16% fewer federal dollars in 2006? What would happen then? The reality is that healthcare costs are generally unpredictable. They adapt to kind of bulk catastrophes like recessions or local disease problems, as well as kind of benefits when we have a new drug that comes on the market for HIV or diabetes or Alzheimer's. We want to be able to address our payments upward to pay for that because that will lead to better lives and better health outcomes.

But if we cap the federal funding today and the best intention governor takes that cap, 3, 4, 5, 10 years from now, it is not clear that the federal government will be a true partner in this game and that the state would be able to provide healthcare services for its people.

LARRY LEVITT: We're quickly coming to the end of the hour. I think it's a nice transition to a final question. Congress will likely continue debating Medicaid this year. We may even see a budget reconciliation bill at the end of this year with major changes to the program.

I'd like to ask each of you, if you had the opportunity to talk to member of Congress, which many of you do regularly, what would you tell them to do in a budget reconciliation bill addressing Medicaid? And Jeanne, maybe I'll start with you.

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Do nothing? Make changes to the program?

JEANNE LAMBREW, PhD: And I spoke to this a little bit earlier - I think that we should have a real honest policy debate about Medicaid, not a budget-driven exercise. There are numbers on the table and the numbers are not linked up to what Congress would do about this.

In all bipartisan successful efforts in the past to improve programs like Medicaid and Medicare, you first come up with the policies and then you kind of work through what is the budget number, the spending or the savings that you would do to make this happen. And in almost every case in Medicaid, we've always coupled savings with reinvestment, recognizing the fact that Medicaid does need in certain critical areas, more resources.

So I'd argue we're having the discussion on Medicaid in the wrong context. We should take this out of the budget context; think about this either through a committee process, a hearing process, and some members of Congress to support a commission. I think we need to really think about Medicaid policy, not think about this, as a part of a federal budget solution that I'd argue is not the appropriate context.

LARRY LEVITT: And Alan, how about you? I know you testified about this before.

ALAN WEIL: As well, I have to reach for my visual aide. I mean we issued a report called "Making Medicaid Work

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for the 21st Century" and I don't want to say it's the guide to the full answer to your question. But I think what it represents is an effort to improve the program in concrete ways that people who actually work with the program on a daily basis think would make it better.

I agree with Jeanne it'd be nice to take this out of the pure budget context. I don't think that's realistic. At the same time, I think it's very important that we not just put it in the ideological context. This isn't just about abandoning the federalism principles that have guided the program since its inception about the relationship between the federal and state government, and making a claim about who is better able to define the program or who's more accountable or who ought to pay for it. Those are great questions. But they aren't budget reconciliation question.

So I think from the perspective of the work we've done, I'd say that there are concrete steps to improve the fiscal accountability of the program to simplify and make it work better for people in the program, people administering the program, and providers who deliver services within the program. We need to have a major conversation about how we pay for long-term care services where Medicaid, by default, is the funder, but it certainly was not anticipated that it would at the outset.

I had to say we ought to slow things down because

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things in Washington can feel awfully slow, but the attention to Medicaid and changes in it has, in many respects, come about quite rapidly and often not based on a tremendous amount of knowledge about what the program does or how it works, or what the consequences of changes would be.

So I would say we have a concrete set of changes that would be incremental and improve the program, but that we better slow down before we talk about some of the bigger changes that some folks have put on the table.

LARRY LEVITT: And Jim, you get the final word here. Should we step back and think about this more, or do you think there's a clear direction that Congress could go in?

JIM FROGUE: Well I think the boiling point is here. I think part of the problem the White House is having with Social Security is that the day of reckoning is a decade or three decades into the future, depending on your view.

The day of reckoning at the state level is here now. Medicaid is now crowding out education spending. It's more than education spending in most states. It is on pace to crowd out everything else. In Florida, Governor Bush said that 10 years from now, Medicaid would go from 25% to 59% of the state budget. If you care about highways or education or law enforcement or anything else, Medicaid has got to get under control.

I think the most important thing that Congress should

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worry about is what makes patients well? What else is this program if it's not about what makes patients well?

Flexibility, so if Indiana does something well, Mississippi can copy it tomorrow. If Oregon does something well, Maine can copy it without even having to do a waiver.

We always got to keep in mind that Medicaid is not a welfare program for managed care organizations. It's not a welfare program for providers or drug companies. It's a welfare program for low-income people who can't get access to healthcare and it's failing in that mission and needs a radical restructuring and local accountability is best. That's the path we need to pursue and we should not go slow, we should do it tomorrow.

LARRY LEVITT: I'd like to thank each of you for joining us for a spirited conversation - Jim Frogue, Alan Weil and Jeanne Lambrew. I'm Larry Levitt and you've been watching kaisernetwork.org. Thanks to our panel of experts and thanks to you for joining us. We'll see you next time for "Ask the Experts."

[END RECORDING]

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