

**Briefing: NCSL 2004 Annual Conference:
Medicaid: Dual Eligibles and Beyond
July 21, 2004**

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SENATOR BYARS: Thank you very much, and this is definitely the largest crowd of the morning, I think our largest crowd of the session the Health Committee has put on so far. I'm Senator Dennis Byars from Nebraska, one of the Vice-Chairs of you NCSL Health Committee, and we do have a distinguished group of presenters this afternoon. First, I would like to take an opportunity to thank the sponsors of our luncheon this noon and this session, former Congressman Hal Dobb, who coincidentally happens to be a former Congressman from Nebraska, former Mayor of the City of Omaha, and is the new CEO of the American Healthcare Association, and Steve Chies, President of AHCA. We'd like to thank them for the lunch. Let's give them a round of applause.

We're going to have in this session, as you've seen in your program, three presenters. Samantha Artiga will be our first presenter. I will introduce all three of them and give you the brief bios so we don't have to interrupt and use additional time between each one of their presentations. Samantha Artiga will be our first presenter. Dr. Robert Friedland, our second presenter. Nelson Sabatini will present third. Ms. Artiga will describe to us what dual-eligibles are, describe how the Medicare Modernization Act affects prescription drug coverage for them. Dr. Friedland will talk about the other services used by dual-eligibles, and the

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significance of this group of Medicaid beneficiaries with respect to overall costs in the state Medicaid programs. Secretary Sabatini will discuss the challenges facing the states regarding dual-eligibles and possible short-term and long-term strategies to address these challenges.

Our first presenter, Samantha Artiga is a policy analyst for the Kaiser Commission on Medicaid and the Uninsured at the Henry J. Kaiser Family Foundation. Ms. Artiga's area of expertise has been tracking and analyzing the impact of changes states make in their Medicaid and S-Chip programs, particularly changes made through waivers. She holds a Master's in Health Services Administration degree with a concentration in Health Policy, and a Bachelor of Arts degree in Economics, both from George Washington University.

Dr. Friedland is the Founding Director of the Center on an Aging Society. He has had a very wide range of research and public policy experience, including being the Chief Economist for Maryland's Medicaid program. Dr. Friedland has written on issues pertaining to the financing and delivery of healthcare and long-term care and retirement income security. He serves on the Board of the National Academy for State Health Policy, the Long-Term Care Education Foundation, and the Editorial Board of Aging Today. He received his Doctorate in Economics from George Washington University in 1983.

Nelson Sabatini was appointed Secretary of the Maryland

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Department of Health and Mental Hygiene by Governor Robert Ehrlich, in fact on March 10 of 2003. This department is the second largest agency in Maryland State Government, and oversees 24 local health departments, operates facilities for the chronically ill, the developmentally disabled and the mentally ill. Also under his auspices are Health Choice, the Medicaid Managed Care Program, the Maryland Children's Health Program, and services to people with HIV/AIDS, laboratory services, substance abuse prevention and treatment services, and regulatory oversight of nursing homes, hospitals and other healthcare facilities.

And I'd like to have all of you give a warm welcome to our panel and our first presenter, Samantha Artiga.

SAMANTHA ARTIGA: Thank you, everyone, for being here today. As was mentioned, I'm going to be talking about who the dual-eligibles are and briefly talk about how they are affected by the Medicare Prescription Drug Benefit, and how changes in their drug coverage may impact state Medicaid spending. I'm not going to go into great detail in that area, because I believe there's a session tomorrow morning that's devoted primarily to that. There was a set of handouts available. They might be gone, but generally, all this information and the handouts that were given out today are available on our website, if you are interested.

I wanted to begin today by introducing you to a dual-

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eligible. This is Mildred Benham. She lives in Illinois. She suffers from cataracts, rheumatoid arthritis, fibrosis of the lungs, high blood pressure. She's 68 years old and is sometimes taking up to 12 prescription drugs per day. She is a Medicare beneficiary and also relies on Medicaid, and as such is a dual eligible. She relies on Medicaid for home services, for help in paying her Medicare premiums and also for prescription drugs. In the quote at the bottom, you can see just how important the prescription drug coverage has been for her. She notes that if she didn't have Medicaid to pay for her drugs, she would cease to exist. It is, in fact, what keeps her going.

So now that we've met one dual-eligible, let's talk a bit more about who are the dual-eligibles. As I mentioned, dual-eligibles are Medicare Beneficiaries that are enrolled in Medicaid. There are in fact, two sets of dual-eligibles. The first being full dual-eligibles. For these people, Medicare serves as the primary payer for their healthcare services, and then Medicaid steps in to fill in the gaps in Medicare coverage, which primarily has been for prescription drugs and long-term care. Medicaid also helps pay for their Medicare premiums and cost-sharing obligations. The other set of dual-eligibles are partial dual-eligibles. And in this case, Medicaid is just primarily assisting them with the costs associated with their Medicare premiums and cost-sharing obligations.

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Most of my remarks today are going to be toward the full dual-eligibles. In order for a Medicare beneficiary to qualify for Medicaid, as you can see, the minimum standards are quite low. They're very poor, often making less than \$7,000 a year for an individual. States do have the option to expand above these levels, but these minimum levels are quite low. When we're talking about dual-eligibles, we're talking about over 7 million people, over 6 million of whom are full dual-eligibles. This accounts for roughly 14 percent of Medicaid enrollment, but it's important to recognize that even though it accounts for only 14 percent of enrollment, expenditures associated with the duals account for over 40 percent of Medicaid spending. It's a proportionately smaller group of individuals who account for a significant amount of spending in the program. This graph again gets in to the characteristics of dual-eligibles, I think very clearly highlighting the fact that this is an extremely vulnerable population, often in very poor health with very, very low income. The first two comparisons are the most stark, showing that over 50 percent are in fair or poor health. Nearly three quarters have income below \$10,000. Over one in five reside in a long-term care facility, and nearly a quarter suffers from diabetes. Here you see the expenditures for dual-eligibles by source of payment. You'll see that it is nursing facilities residents for whom Medicaid picks up the majority of costs, and it is these residents who

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are generally the most expensive among the dual-eligibles. This helps explain why costs for dual-eligibles tend to be so high within the Medicaid programs. You'll see overall, Medicaid is picking up over 40 percent of all the costs of dual-eligibles, so they have a substantial stake in dual-eligible care. Here you see exactly how expensive it is to care for individuals in nursing facilities. Overall, dual-eligibles are much more expensive than other Medicare beneficiaries, and the costs associated with nursing facility residents are quite high.

Now I just want to briefly touch on what happens to dual-eligibles under the Medicare law. As we know, the new prescription drug discount card became effective recently. Full dual-eligibles are ineligible for this card, and so have been unaffected by it. However, on January 1st, 2006, when Medicare prescription drug coverage begins, their Medicaid financed prescription drug coverage will end. That is, they will no longer be able to rely on the coverage they've had through Medicaid. They are expected to sign up for Part D Plan. However, although HHS is to develop procedures to enroll dual-eligibles in Part D, if they do not sign up by January 1st 2006, they could experience a short period of time where they do not have any drug coverage at all. Their Medicaid drug coverage will end. Once they do get enrolled in Part D Plan, whether or not their coverage will be better or worse to costs depends on a number of factors. The first is the comprehensiveness of the

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Part D coverage in comparison to what they had under the Medicare program. The second is the co-payment obligations under Part D compared to what they had under Medicaid. Although the Medicare prescription drug benefit has substantial subsidies and protections for low-income people, largely shielding them from co-pays, there are co-pay requirements, and in many cases, people who are getting their drug coverage with Medicaid today do not have any co-pay obligations at all. So for them this will be perceived as somewhat of an increase in out-of-pocket costs. The last thing facing the duals will really be how well they are able to navigate the complexities of moving into a Part D plan, and getting their coverage through that Part D plan.

So, how are state Medicaid programs going to be affected by this transfer of prescription drug coverage for dual-eligibles from Medicaid to Medicare? As was mentioned, on January 1st, 2006, dual-eligibles can no longer get their prescription drug coverage through Medicaid, and similarly states can no longer draw down federal matching funds to provide them any prescription drug coverage that could be provided through Part D. States will have the option to turn to state-only funds to provide coverage if they think that the Part D coverage needs to be supplemented for these individuals, but I think it's really, really important to note that they will not have the option of touching into any federal Medicaid

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matching funds for drug coverage for this population anymore. Now, I know that when the prescription drug benefit was being anticipated, a lot of states considered moving dual-eligibles' prescription drug coverage from Medicaid to Medicare would allow them to reap a specific amount of savings within their Medicaid program. However, it turns out that states are going to have to continue to finance much of the prescription drug coverage for the duals through what are called callback payments. Basically, states will have to pay back the federal government payments based on a portion of the anticipated savings that they achieved from transferring the prescription drug coverage from Medicaid to Medicare. Additionally, states will have to become responsible for a number of actions surrounding the administration of Medicare's low-income subsidy program. As they help get individuals tied into this low-income subsidy program, they also have to screen individuals for Medicaid eligibility. We're afraid there will be a potential woodwork effect of more people becoming enrolled in Medicaid, which could increase state Medicaid costs. In the long run, what does this mean for state Medicaid spending? You can see that most of the spending that states have for dual-eligibles is outside prescription drug coverage, so aside from the new prescription drug benefit, they still will be left with a substantial chunk of spending on dual-eligibles. And you see the small yellow pie on prescription drug spending for dual-

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eligibles. As I mentioned these are not going to achieve savings of that entire pie. In fact, most of that pie will go back to the federal government in terms of the callback payments, so states are not going to get the entire savings from that pie. It will only be a small sliver of it. The bottom line is that states are going to remain responsible for a substantial share of spending associated with dual-eligibles.

Just to wrap up with a couple of key points, it's really important to remember when we're talking about dual-eligibles that we're talking about a population that is very, very poor, and often has extensive healthcare needs, or often are residing in nursing home facilities. Secondly, changing the dual-eligibles' drug coverage from Medicaid to Medicare is a huge policy change. It's requiring a substantial amount of implementation and monitoring and close attention to how dual-eligibles will be affected. There is the risk that some dual-eligibles may run the risk of ending up without any prescription drug coverage during the transition period. It's a question of whether dual-eligibles will be better or worse off under Part D than under Medicaid, and I think the answer to this question will vary from state to state and from individual to individual, depending on what Part D plan they end up in. Additionally, I think the complexities of Part D coverage are going to be quite difficult for this population, again, recognizing the situation that they're in. Often they have

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impaired abilities. Lastly, the important point that states are still remaining responsible for a substantial share of an individual's expenses, including long-term care. It is the long term care costs that are much more costly, and additionally because they have to pay back a lot of the savings that would be accrued from transferring the Medicaid prescription drug coverage to Medicare. Thank you.

DR. FRIEDLAND: Good afternoon. It's a pleasure to be here with you to talk about this very difficult topic—emotional, expensive, perhaps what healthcare is all about is contained in this one topic of the population that we're talking about here. Dual-eligibles are Medicare beneficiaries with significant health or long-term care needs. With few financial resources relative to their health or long-term care expenses, compelled to apply for assistance from the state. Compelled for a healthcare reason. About 14 percent of Medicaid beneficiaries are also Medicare beneficiaries. This includes about 90 percent of Medicaid beneficiaries 65 or older, and about 34 percent of Medicaid beneficiaries under the age of 65. Eighty-five percent of dual-eligibles, as we just heard 7.2 million were fully Medicaid eligible, which is 6.1 million in federal fiscal year 2002, so small percentage are in the Medicare sharing program. Most of them are fully covered, fully dual. Compared to other Medicare beneficiaries, dual-eligibles are twice as likely to report their health as fair or poor,

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twice as likely or more to have hypertension, diabetes, heart disease, lung disease, Alzheimer's disease, a mental disorder or have had a stroke. This is a population with co-morbidities of chronic conditions. They are four times more likely to have limitations in three or more ADL's (activities of daily living). Those kinds of things needed to function from day to day, like getting out of bed, using the toilet, eating, dressing. They are nearly nine times more likely to live in a nursing home. Now even for the population under 65 on Medicare, this is a disabled population, total disability from a medical standpoint, can't work, can't work for 24 months, then become eligible for Medicare, so even in this population, the Medicare beneficiaries under 65 who are disabled but duals are 50 percent more likely than other Medicare beneficiaries under the age of 65 to have limitations in three-plus activities of daily living. So even among the disabled under-65 population, they're even more substantially functionally dependent on other people. So it's not surprising that dual-eligibles need considerable medical care and assistance. They need primary care, including psychiatric care. They need acute care, nursing care, speech and occupational therapies. They need a whole array of supportive services. So that of course means physicians, in-patient hospital care, outpatient hospital care. These are the budget lines. They need home health care, medical equipment, home modifications, adult day care, personal care, and nursing

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home care. Of course they need prescription drugs. In fact, prescription drugs are the glue that has influence on almost everything else. Not having access to prescription drugs, not having access to the right drugs could have consequences on you in-patient hospital care. Of course, if you have in-patient hospital care increasing, you have physicians attending to that, since they are in charge of the healthcare system, but you could also have a demand for more admissions in nursing homes. Of course, as you know, this is the Medicaid population, but compared to 18 percent of all other Medicare beneficiaries, 77 percent of duals have incomes under \$10,000. Think about your budget, your household budget. Eight hundred and fifty dollars a month or less. Rent, food, transportation to the doctor, medical insurance expenses, prescription drugs, uncovered healthcare expenses. Certainly by definition, countable assets—obviously that's financial assets under the Medicaid rules—countable assets less than \$6000 per couple in the Medicare savings programs, or \$3000 for couple for full-Medicaid benefits. Those are 4,000 and 2,000 respectively. Not a lot of resources. So low-income Medicare beneficiaries with few resources and poor health need the coverage provided by Medicaid. Of course persons in poor health drive the healthcare expenditures. Duals account for 25 percent of Medicaid enrollment, but 70 percent of Medicaid expenditures. Duals are about two times as expensive per person as other Medicare

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beneficiaries. Duals in nursing facilities are two times as expensive as duals in the community. About a third of Medicaid expenditures for aged and physically disabled are for long-term care. There are about 1.7 million Medicaid beneficiaries in nursing homes, about 1.4 million in home-included [misspelled?] base services. Bryan Burwell, who I know is speaking here tomorrow, estimates that Medicaid spends 54 billion in long-term care expenses, and 30 billion in other expenses, plus Medicare spends 49 billion, almost 50 billion on this same population. So the long-term care population is costing about 133 billion.

So we have a fragmented financing of the duals. Medicare covered 43 percent of expenditures, and among the duals in the community, Medicare covered 70 percent, Medicaid covered 17 percent. Medicaid covered 38 percent of the expenditures, but among duals in nursing home facilities, Medicaid covered 55 percent, Medicare covered 21 percent. And patients in private insurance covered the remaining 12 percent.

So here is the breakdown of Medicaid expenditures for duals, not including the Medicare part. We see that long-term care is the biggest. Eighty-three percent of that is for nursing home care. And prescription drugs are only 14 percent, only 14 percent, but as you heard, through the claw-back provision, you will still be paying for most of that, plus some administrative costs.

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As we're moving from an open formulary to a closed formulary, that is, the private plans from which the Medicaid beneficiaries will be choosing will have closed formularies, and I'm very worried about what those formularies will look like. It will be very much in the development of the private market under the guidelines of the Secretary of Health to establish guidelines for what is a class of drugs, and within a class the companies only have to provide two drugs, and so if that coverage is less, or at least for the chronically ill, then we might see expenditures increase for Medicare covered services in particular, but also for acute care Medicare premiums to help finance Part D. I think you will see, by virtue of containing this slice of the pie, depending on how the private plans develop, we will see the whole pie get bigger.

Medicaid is critical for duals. Duals, in fact, underscore why healthcare is an insurable event. It is a small percentage of the population that consumes an incredibly large percentage of the resources. Most of us, for most of our lives, spend very little, if anything, in healthcare, but at some point, many of us develop a condition, and when we develop multiple chronic conditions, that is when we become high users of healthcare. For most of us it occurs much older in life. For some of us it occurs at a younger age. The financing of duals not only underscores the fragmentation that exists within

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health and long-term care systems, but also between health and long-term care systems. Any of you who have ever, unfortunately, experienced care in the hospital, can attest, probably, can tell stories about how uncoordinated the care was within the walls of that hospital. How very often you needed family members or others to help improve the coordination, an ombudsman, if you will, an advocate on your behalf, in our hospitals, in which the walls are contained. As soon as you move away from the hospital in the healthcare system, there is increasingly more fragmentation, and it's all in a system in which the physician is in charge, someone we respect, someone we count on who's in charge. So there's fragmentation in the healthcare system, and the further away from the hospital you get, the more fragmentation there is. In the long-term care system, there is not a physician in charge, so there is even more fragmentation, particularly when it comes to home-included based services, and certainly between healthcare and long-term care. And most people who need long-term care need a lot of health care. Better coordination could help, but it isn't a silver bullet. It's not easy. We don't know how to do it. It does require extra resources to do it right. But it could help a lot. But it is long-term care that is driving a substantial portion of the expenditures. Thank you.

SECRETARY SABATINI: Someone's going to have to show me how this works, because—

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SENATOR BYARS: While we're getting set up, I just wanted to compliment in particular the legislators for chewing with their mouths closed and not belching after they ate. Thank you very much.

[Some discussion off-mic about the Secretary's slides.]

SECRETARY SABATINI: We're obviously having some technical problems, but let me get started. First of all, I think there were copies of my slides that were available for people to pick up. I'm also told that they will be on the NCSL website. Hopefully we will find them shortly, but if not, we'll do the best we can without them. Quite frankly, I'm not a big Powerpoint fan anyway. So, I find that I don't like to have people read slides to me when I'm in an audience, and I prefer not to do that to them. So, why don't we just start, and I'll use these as a general outline.

I want to preface my comments to talk a little bit about Medicaid. I have been around and involved in the Medicaid program for much longer than I even like to remember. I was with the federal government in the mid and early 1960's and was then involved with efforts of Secretary Cohen, who was putting together HR1, the Medicare and Medicaid legislation, Title 18 and 19 of the Social Security Act. Medicaid is a program that is something near and dear to my heart. It was for the first time kind of a statement in this country that healthcare is not a privilege. It is a right, and that poor people have a right

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to access high-quality health care. I am very, very concerned about the future of the Medicaid program. I think the program is facing a major crisis, and I think it is in jeopardy, and I'm concerned about the impact that that's going to have on the ability of the poor people in this country to access high-quality health care. For the first time last year, Medicaid started costing more than Medicare. When we did 18 and 19 in the 60's, Medicaid was almost an afterthought. Secretary Cohen's primary focus was Medicare. He was one of the original architects of the Social Security Act. We were the only country in the world that had a Social Security system that did not have a healthcare component, and he was determined that his legacy was going to be the creation of a healthcare benefit as part of our Social Security System. At the time, there were a lot of state programs and various kinds of grant programs that were around for indigent healthcare. We looked at it and said, why don't we sweep them all together and put them into this state/federal partnership with a kind of maintenance of effort concept, and we'll have a uniform kind of program to guarantee poor people access to healthcare. That afterthought, last year is costing more than Medicare. I saw recently, in the last week are two, numbers on the 2004 expenditures, and Medicare is now up to 289 billion, Medicaid is projected to come in at 304 billion dollars in costs. There are projections that I have seen that have come from both sides of the political spectrum.

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I've talked to Dave Kendall from the Progressive Policy Institute, some of the guys at the Heritage Foundation, and both of them say that we could easily be facing a 600 billion dollar Medicaid cost within the next decade. Ladies and Gentlemen who are legislators, if that happens, your job will be greatly simplified because you'll be able to deal with your state budgets in about 15 minutes. You will fund Medicaid, the other entitlements, and then you will go home, because there will be zero dollars left to cover the costs of any discretionary spending. It can't continue. We've played and nibbled at the edges to try to contain costs over the last several years. We've squeezed providers. We do little bit here, a little bit there, pull some rabbits out of the hat on creative kinds of ways to leverage federal dollars, but that's over. That's over. The program needs some fundamental restructuring. And when you look at the data that you just saw by the presenters here, what jumps out at you is that there is a small definable segment of the population that is using a disproportionate share of the dollars. In Maryland, we estimate that about four percent of the population consumes 30 percent of the dollars through long-term care expenditures. Nationally, I think that that number is something like eight percent of the population consuming 43 percent of the dollars. The difference, I believe, is attributable to some very, very stringent level of care standards that we have in Maryland, and also very

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restrictive eligibility requirements on the income and asset side. We are spending these huge sums of money, and what we are still seeing is an incredible amount of unmet need. In our state we have literally thousands who do not meet our level of care standards who are struggling to try to find a way to exist with help from neighbors and others in the community in doing the best they can, but we're not meeting those needs and we're not going to meet those needs unless we can find a way to free up resources and redeploy those resources to meet unmet needs.

I've looked at and tried to think about how we're going to do that. I think the first thing we need to try to do is deal with this fragmented financing, having Medicare and Medicaid coming on two totally separate financing streets. The deal with the dual-eligibles is not working. It's not coordinated care, it's not dealing with the person in their totality, and they need to be brought together. Many years ago there was a man in San Francisco named Dr. G who ran a clinic in Chinatown called the unlocked clinic. He came up with the concept of bring and coordinating Title 18 and Title 19 into a single capitated payment, and then aggressively managing the care of this very, very costly population. What Dr. G did in Chinatown was a success in several models throughout the country, the so-called Pace demonstrations have proved that it can work. What the Pace model does though, is start out with the frailest and most fragile of this population, and in order

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to effectively manage the care and control costs, you have to have all of the people - the very frail, the very sick, and that portion that is not as frail and not as sick. You should be able to realize some significant savings, especially on the Medicare side.

Then we need to concentrate and look at and find ways to de-institutionalize the elderly in this country. The most costly setting for caring for the dual-eligible rolls are for those who are in nursing homes. We need to find a way. We have proven through the various demonstration projects that all of us have in our various states that a significant portion of the people who are in nursing homes today can have their needs met in an alternative setting at lower costs and improve the quality of life by doing it. We proved that many years ago when we de-institutionalized the developmentally disabled from our institutions. Lower the cost, better quality of life. We need to find a way to do that, and to do that aggressively with the elderly population.

My concept of saying to bring the 18 and 19 payments together, when we did it with the developmentally disabled said that you can move someone from an institution in to the community if the cost was equal to or less than the institution, and once you did that, you had to decertify the bed. You could do that and have a waiver like that because at the time, all the beds were owned by the state. The nursing

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home beds are primarily privately owned in this country, and I'm not about to advocate the confiscation of private property.

But I do believe we need to put a financial incentive and a barrier at that front door. You do that in my opinion by creating this jointly capitated payment. There will be a financial incentive by doing everything you can possibly do to keep people from going into the nursing home, move people out of the institution that can be cared for in a lower-cost setting, and coordinate the care. I think that we have no choice but to aggressively move in that kind of direction, and do that. We have to do it in a way that makes sure that we are protecting the rights and the needs of the consumer. It should be consumer directed. There's no reason why you can't have a managed care program that does that. I believe you can guarantee those consumer protections.

We have to look at the way we regulate and the whole quality system that we have in place, and stop regulating process, but really regulate and look for results. It's doable, and we can do that. We can build that into this system. We need to then be able to track and see what resources we can free up and re-deploy to meet unmet needs. There is not going to be any new money available, and just arbitrarily making budget cuts in the future are going to result in poor people having less access to high-quality care and a deterioration in the quality of that care.

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Lastly, it's absolutely essential that government start making business-like decisions and behaving like a business. I believe with every fiber of my body—I believe it today and I believed it when we were putting Medicaid together—that the primary beneficiaries of Medicaid are poor people who have a right to high-quality care, and that the second obligation we have as government officials is to be a prudent buyer of healthcare, make businesslike decisions to get the very best we can possibly get out of the taxpayer's dollar when we buy that. We are not an economic development program. It is not our role or our responsibility to protect industries. We're here to protect poor people, and we're going to have to start behaving in a businesslike fashion, and creating the competition and the energies necessary so that we can get the best dollar possible. Because if we don't you will see a significant erosion in public support for this program, and then you will see poor people being put in jeopardy. We owe them more than that and we can't let that happen. Thank you.

SENATOR BYARS: We have a mic open in the center of the room. Anyone who has questions or comments for our panel, please come forward now.

MALE SPEAKER: A question for Mr. Friedland. The Social Security Act contains a number of consumer protections for Medicaid recipients in regard to essentially closed formularies; prior authorization must be given for any patient

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that wants access to a non-preferred drug on a preferred drug list. Is it your understanding in the Medicare bill that closed formularies are allowed? And are those similar consumer protections included in the care bill that are included in the Social Security Act to protect Medicaid recipients?

DR. FRIEDLAND: It is my understanding that closed formularies are allowed. That the appeals process requires hitting a certain threshold before you can make the appeals process, meaning that you would have to pay out-of-pocket for that drug, and then bundle, if you will, that appeal, so it's not frivolous, I suppose was the intention. And that it's the individual in this case who has to advocate for the exception, not the doctor. Most managed care plans that you're probably a participant in as a member, have an appeals process, by which the physician has to ask for the exemption of that particular drug and make the case for it. It's part of business operations that they expect that, and that way there's a mechanism in place to both control for it and allow for it. But in this case, we're expecting frail individuals in nursing home beds to spend the time advocating for this exception on their own, and that is quite a departure from the way that the market works. I'm not an expert on these things, but that strikes me as putting all the onus on the frail in a way that's quite dangerous. Also, the subsidies that come into play to buy the plan are for the average plan, and if you're designing a plan

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to cover the average Medicare beneficiary, that's a very different kind of thinking than designing a plan of coverage for the chronically ill. So, I think there's certainly lots of opportunity to make sure these rules go into effect in ways that make this positive, but certainly the risk-pooling mechanisms that got put in place, the guidelines by the secretary are going to make a big difference, and those are the details that really will matter if you are chronically ill with co-morbidities that have drug interactions for which the generic is just not quite good enough anymore, and what is on the cutting edge will mean the difference that will make them more mobile, but that's not on the list because the generic was. I'm really worried about that.

MALE SPEAKER: First of all, let me say that I'm a very strong advocate for the elderly being in the right setting when they need long-term care. I think the way long-term care is typically being presented, and presented here, is that the nursing home was being pointed out to be a \$44,000 a year cost, when in fact, the patient with their Social Security benefit offsets that by 40 percent. Sixteen thousand dollars on average goes back to offset that cost. It is never portrayed in any of the statistics that are presented. And if you get out your handy-dandy calculator, and you have a total-care patient, which is the kind of patient that would typically be in a nursing home, multiply minimum wage times 24 hours a day, seven

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days a week, through 65, and you'll come up with a number like \$85,000, which doesn't include rent, food, or any of the other amenities you would have to support of you were in a home setting. All I'm suggesting is, it needs to be presented in a way that really reflects the costs, the needs and the demands for those particular individuals. Thank you

SECRETARY SABATINI: You still can't deny the fact that four percent of the population is consuming. I mean, 24,000 people in Maryland are consuming almost a billion dollars in care. Just in long-term care. I agree that there are some people for whom an institutionalized setting and who are elderly is the appropriate setting. I've never said that everybody has to leave and get into an alternative setting. But I believe that there is a significant number of those people who could be in an alternative setting where the cost is less. And we've proven that. We've proven it with demonstration waivers, with some of the most profoundly fragile human beings that exist when we institutionalized the developmentally disabled. Yeah, \$44,000 is offset by the spend-down provisions. The matter is that it's consuming a disproportionate share of the dollars, and we need to find alternatives.

SENATOR SCOTT: Charles Scott, Wyoming Senate. My question is relating to the new Part D Medicare drug benefit. We know it's going to be run through private entities. We know we've given them the tools to squeeze the drug companies pretty

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hard with the absolute formula, so potentially they're going to save some money. The question is, are they going to do it in ways that will be helpful to our Medicare recipients, or not? It seems to me that with private entities we can predict they're going to react to what their incentives are. The question I have for you all is, how are the private entities going to make their money in this program, because that's what they're going to ask, and what incentives does the program have for their behavior, because if we know that, we can predict how they're going to behave, and if it will be helpful or harmful to our people.

SECRETARY SABATINI: I think there's some evidence on what the behavior will be just if you look at the pricing activity of the pharmaceutical industry just in anticipation of the discount card. They saw that the discount card was coming, so they started raising their prices to reduce the impact of that to the greatest degree possible. I cannot sit here and advocate on behalf of the recently passed Medicare legislation. There's a lot about it I find very disturbing. I think it's going to end up costing states money. It's not going to save us money in our budgets.

DR. FRIEDLAND: I think they'll make the money from the premium, and whatever discount they can squeeze out of the pharmaceutical companies. However, they're starting from scratch, and as you know, the states that did this a long time,

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figured out how to do that squeezing. I think the markup and the premium are what are going to keep them in business or not. Of course, that's the freestanding, and I suspect most of the action will be in the managed care ones, the Medicare Advantage. They would have some ability to pass on savings, if there are savings. But as we know, that savings comes from encouraging through selective contracting, encouraging the least sick, and discouraging the most sick from the plan. So in those cases, the average or better than average, the healthy Medicare beneficiary could in fact see improvements through that Medicare Advantage. But we do know how managed care has managed to stay in business in an environment where we have choices between managed care and fee-for-service

SECRETARY SABATINI: There was some evidence, and Dr. Wolinsky has the information that shows that in private sectors, the growth of prescription drug costs has leveled off some in the past few years, and there are indications that some of that is attributable to more aggressive management or pharmacy benefit programs. There's a great deal done. In terms of will any of those savings be recycled to make the program more generous? Don't look for that in our lifetime. I mean, they've got a hole to plug from Tom Scully's estimates that isn't going to be funded for a long time.

SAMANTHA ARTIGA: I think to your question about how this is going to affect the Medicare beneficiaries, I think

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that raises the other question, of which beneficiaries are you talking about? Because I think Dr. Friedland and I showed tonight that the dual-eligibles are really a different group of Medicare beneficiaries than the other, much sicker, often requiring many more drugs than, per se, the average Medicare beneficiary. As was mentioned previously, the low-income subsidy will only cover a premium for an average or below average Part D plan. I think it raises real questions over what sort of plans they can enroll into without paying extra costs that they might not have, whether those plans are going to cover all the drugs that they need. This is also a population that probably has changing healthcare needs and drug needs over time, and they may land up in a plan that at one time fulfilled their needs, and perhaps later is not fulfilling their needs as much, and really the flexibility to move around between plans that easily.

MALE SPEAKER: Thank you. My question is, help to point me in the direction if there is any data that supports the idea of managed care being cheaper than long-term care. Can you point me in the direction of that information?

SAMANTHA ARTIGA: You mean home and community-based care settings?

MALE SPEAKER: Yes.

SECRETARY SABATINI: I think I would assume CMS has set up data that shows as a result of the home and community-based

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waivers that care in an alternative can be delivered. Needs can be met in a less costly fashion. The problem in saying, does managed care save money, is that by and large, with just a small handful of examples, we've really not had a system of good managed care. What we've had is primarily managed costs. There's not question in my mind that good, effective, coordinated, managed care, true managed care, and not just trying to save money through putting up barriers to access can and will save money. We're going to have to accept that the healthcare system in this country has to be used in a more disciplined fashion, or we will not be able to afford what we're doing.

DR. FRIEDLAND: About the costs, let me just say that there's no question that the cost of nursing home care is quite sufficient. The cost for what you're getting. In other words, you're getting 24-hour nursing, shelter and food. The question really is, can people have enough support in the community for an expenditure that's less than 24-hour care? So this discussion gets very confused between cost and expenditure. There's no question that the daily costs of a nursing home, if you can parcel that out into smaller pieces, if you could keep someone at home, then you could spend less, but the cost of sending someone to your home is much greater than having a nursing station right there. Whether the person needs 24-hour nursing, and I think most people now in nursing homes probably

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do need 24-hour nursing, we may prefer care at home, and the question is whether we're willing to pay for that. I think on a cost-basis, nursing homes are pretty inexpensive, but you're buying a lot more than just the service. You're buying food, shelter, and 24-hour nursing.

MALE SPEAKER: I'm from Mississippi, and we have several here from our delegation from Mississippi. Probably the most burning political and moral issue in our state right now, our governor proposed and is going to, we think, cut of 65,000 dual-eligible people in our state that have just a few dollars more than what would entitle them to the SSI. And as a result, some or all of them will lose their healthcare benefits. He has graciously extended to September 15, and he may graciously extend it a few more days. We are being besieged by their families and by the elderly people asking what we are going to do about their prescription drugs. People are saying that they are having to make the choice between eating and having prescription drugs. It is a human issue. It is a great moral issue in our state. My thought, and I want some comment about it, is, if we save some dollars on prescription costs on these people by cutting off their prescriptions, would you not think that in the long-term that these people will be sick because of not taking their medications and regimens, and then may require nursing home care, or other care that would be much more expensive to the healthcare institutions in general than the

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payment of the help on their prescription drugs. And if they don't what is that saying about America, to allow people who have worked all their lives not to have decent prescription drug coverage? It is a shame in this country alone in the Western democracies that we are in this position.

SECRETARY SABATINI: I'm not going to comment on what Governor Barber is doing there. I mean, there's no question. Prescription coverage is an option under Medicaid. States don't have to do it. It's crazy not to do it and have a Medicaid program included, because it saves you money. So, yeah.

MALE SPEAKER: Sanity may enter into it. I don't know.

SECRETARY SABATINI: Mississippi is facing a very difficult situation.

SAMANTHA ARTIGA: I think what you're seeing in Mississippi is a next step in what we're seeing in other states. Over the past few years across the states we've seen a number of cutbacks in eligibility and services, both through options available under current law and waivers, and the states are turning to these more vulnerable populations, with Mississippi as an example. What we're seeing with all the populations is that when you cut back on coverage and services and when you increase cost-sharing obligations on people who can't necessarily afford to pay them, you are going to see those costs pop up within your state's healthcare system, at your clinics, be it at your hospitals, or having sicker

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individuals seeking care at later stages of disease. So you don't get rid of the costs by stopping the pay for things, they just pop up elsewhere in your system.

DR. FRIEDLAND: I expect, unfortunately that the in-patient hospital costs will exceed what you have hoped to save with lots of pain and suffering in between and people dying at home.

MALE SPEAKER: I'd like to make three observations with respect to the home and community-based services issue. The first echoes, Robert, your point that, at least in my opinion that when we look at the dual-eligible population, the jury is still out as to what the financial consequences will or won't be. I agree with you that nursing home care is a cost-effective alternative for people who require 24-hour care and don't have appropriate community supports. In addition, the demographics of the nursing home population has changed very rapidly in our state, in Pennsylvania, for example. Something on the order of 48 percent of nursing home residents are discharged to home within a short time following their admission. The rest of the population, I would agree is heavily dependent on 24-hour care. The degree to which we are going to save money on home/community-based services globally, is an open question. I know that in some states which have aggressively pursued home and community based expansion what's ended up happening is the less acutely needy "nursing home eligible" end up in the community-

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based setting. In the nursing home setting, the level of acuity therefore goes up. You don't get as substantial a drop in occupancy as you might expect. The offsetting costs in the nursing home, particularly in the case-mixed system, where acuity drives costs may in fact mean that the system overall does not net any savings and may cost more. I think that's the question that merits consideration in the context of budget.

The second observation concerns quality in home and community-based settings. I'm sure all the panelists are aware that the GAO concluded that state oversight of Medicaid home and community-based programs was so inadequate that the federal government couldn't draw a conclusion as to whether or not there was anything that looked like quality oversight. If we start to advance the quality oversight system in home and community-based settings, that necessarily will carry with it a cost. Similarly, the adjunct to home and community-based expansion is the notion of aging in place. And if you're conceptually saying that regardless of where people exist, in their homes, in private apartments, in assisted living and care settings or in nursing homes, they should essentially get the same degree of care and services, then it logically follows that they should have the same training requirements for direct-care workers, education requirements for direct-care workers and so forth, which also increases the cost of home and community-based services.

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The final point I will make is really a plea. And that is, when I look at the home and community based infrastructure that exists, certainly in Pennsylvania, and in many areas of the country, it is inadequate to really support the type of relocation that you're suggesting, that other advocates of home and community based services are suggesting. The reason I say it is a plea, is that virtually none of those advocates, including yourself suggest that nursing homes should not exist, and I argue that nursing homes, particularly in rural areas, particularly in smaller communities are already major employers, are already major economic forces and can become the hub of an infrastructure around which a home and community-based network evolves. By articulating this issue in an adversarial context, institutions, versus what people want, we are undermining our ability to achieve that end, and I don't think that benefits any provider, regardless of what type they happen to be, and I certainly don't think it benefits poor people.

SECRETARY SABATINI: I would agree with your comments about the infrastructure. I think one of the reasons the infrastructure doesn't exist today is that we haven't created a market to incentivize the creation of that infrastructure. What we have to do as part of this is make sure that we provide the free-market incentives to build that infrastructure and be very careful with how we implement this program so that we don't

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more forward without making sure that that infrastructure is in place. When I look at what we did with the institutionalized mentally ill as compared to the institutionalization of developmentally disabled, I think we did it right by the developmentally disabled. I think it was a horrendous disaster for the mentally ill, and we need to be very careful. With regard to state oversight, there's no question that the GAO's been critical with states in terms of their oversight and the quality of their oversight of community-based programs, but the GAO's been equally critical of state performance in oversight of nursing home quality and yesterday issued a pretty damning report on the oversight and regulatory quality of hospitals. The system that we have for regulatory oversight, I believe is flawed across the board. I think we need to do it differently. We need to focus on outcomes, not process, and be able to do it more aggressively.

FEMALE SPEAKER: Good afternoon. First of all, I want to compliment you on your ideas of outcomes and not processes. I am a long-term care provider from Texas, and I have felt like that for the last 25 years, so I commend you for that. My question is, realizing that Medicaid was designed for the poor, what about the transfer of assets? I'll assume that that is nationwide. In Texas we have many, many people transfer hundreds of thousands of dollars in order to qualify for Medicaid. Would that not be a process that you need to look at?

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SECRETARY SABATINI: The transfer of assets, and I have looked and asked, intuitively, there's no doubt in my mind that it adds a huge burden to state budgets, but I can't figure out a way to quantify what that is. I agree, it's something that absolutely has to be dealt with, and that primarily at a federal level. We've looked at some things, but what you can deal with the self-improvement problem is very limited. Perhaps what is the worst part of that is that ultimately you would want to say that long-term care insurance is something you would like to see take off, and people taking responsibility and planning for their future needs. I think one of the biggest reasons that long-term care insurance is not taking off is because of the very aggressive and perfectly legal behavior of the elder [inaudible] in telling people, "Why bother buying long-term care insurance? We can show you how to get that protection through the state."

FEMALE SPEAKER: Thank you.

SENATOR BYARS: We'll take a couple more questions. We're running up on time, and I think we can handle everybody that's at the mic right now.

MALE SPEAKER: Let me ask Samantha a question about the claw-back provision where dualies are in a managed care program. Typically managed care reports costs of drugs back at their payment price to pharmacies. And we all know that they get discounts, rebates, kickbacks that reduce those to offset

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their overall bid, if you will, to the state. Is the claw-back on the reported cost of drugs, which would mean it would be a greater amount than they are actually paying, and that when they come back and bid, they're going to have to bid in a larger amount on their subsequent bid when you pull the prescription program out of their program. What is the impact of that?

SAMANTHA ARTIGA: I believe rebates get built into the formula used to determine the claw-back payments for the states. I'm not an expert on the claw-back. We have a paper on our website detailing how the formula is calculated as best as--

MALE SPEAKER: But if you don't know what the number is, even Medicaid has reported because of the protection that goes on with the managed care organizations, they don't have to report those costs--

SECRETARY SABATINI: For me it's not an issue because our dual-eligibles are excluded from managed care. What the claw back is going to cost is money. Claw back is based on a 2003 base year. Most states started aggressively controlling costs in their prescription drug programs in 2004 and 2005, with things like preferred drug lists and supplemental rebates and so on. You're going to get penalized for making, doing a better job in managing it because the base year that they're using.

SAMANTHA ARTIGA: That's the concern that we've heard

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from a number of states is being locked into 2003 spending, and exactly what you say. They're putting cost-containment measures into place that are not reflected in that, and that is something that is part of the legislation and cannot be changed unless you go back to the actual legislation.

MALE SPEAKER: But it also drives the subsequent managed care bid back up because they don't get to take advantage of it.

FEMALE SPEAKER: Hello. I have a question for any of you. I'm with the National Association of Hispanic nurses. I am a Latina and a nurse practitioner. I would like for somebody to give me the demographics. What does the population in nursing homes look like, number one, and then number two, just as a comment, I would expect that it's the dominant population, Latinos in our population are growing in the United States. We do manage to keep our seniors at home, and in fact, we're subsidizing your programs because we do keep them at home. When you try to get programs, for example, in rural Colorado—I'm from rural Colorado—it's difficult to get programs for a rancher father who's 90 years of age. I just wanted someone to talk about that. I think that with another program that I've been involved with, the developmentally disabled, even when some of the parents wanted to keep their children who are developmentally disabled home, the state, because of the laws, wouldn't allow families to be subsidized to take care of their

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own child. I'm concerned as to some of the laws that have gone on regarding how we care for both of those populations.

SECRETARY SABATINI: With regard to your first comment about the cultural difference, you're right. In those states that have very large Latino communities, they're also locations where nursing home beds per thousand are usually lower than most other places. Secondly, one of the reasons I like a capitated system is not just because I'm interested in shifting risk and dumping risk off. As a matter of fact, I'd want to propose something where there is risk-sharing, but the real beauty of a capitated system is that it gives you flexibility in using those dollars, so that you're not locked into a rigid menu of services that you can't deviate from. So that in theory, you would have a system that says, what would you need to take your loved one home? Do you need modifications? What kind of support? Do you need maid service? What kind of respite services? I think that's one of the advantages of a capitated system, that it gives you truly the flexibility to meet and do a better job in meeting needs and not to be locked into a very defined set of services. And the other thing I want to mention is an area where I think there's a significant potential savings, on the kind of general model that I'm proposing, is in the reduction of in-patient hospital use. I mean, we have this perverse incentive for dual-eligibles, many of whom a lot of them could have their needs met by short-term stays, by direct

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admission in a high-quality nursing facility, but you can't do that. And the incentive is absolutely the opposite, for them to move people into the hospital for a short-term stay, rather than moving them. I think flexibility that you provide offers a great potential for savings.

FEMALE SPEAKER: I just wanted to comment, because often the minorities are the ones that are supposed to be driving the Medicaid healthcare costs, and yet, none of the health disparities are just growing and growing, and so now as we do all these cutbacks and reduce access to medicines, you'll never have a workforce to keep the society going, so it's really concern. And when you think about the folks who are service people, they don't make wages good enough to sustain them, and their SSI if they're ever going to be on SSI if they're disabled, or for those that are disabled, that's CI, so they're in a lose-lose situation. Just wanted to make those comments. Thank you.

SENATOR BYARS: This will be our last questioner.
Doctor?

ALFERD: Yes sir, Alferd from Mississippi. Just for the record, I'm not particularly fond of our governor's move to take 65,000 off the rolls, and in fact, I practice in a rural part of the state, and have had to look at many of my patients and try to explain to them how we're going to get through the next few years without those resources. In fact, when we were

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scheduled to take those services away on July the 1st, many of us predicted that that would be one of the darkest days in Medicine in Mississippi. I would just like to make a comment if I might. The term 'defragmentation of care', those of us who are actually delivering the care think a good term might be holistic. I am a family physician, and I feel like family physicians, primary care providers, that while we're hunkered down in the bunkers, taking mortar fire and trying to figure out how we're going to get through the next few years, that there needs to be some thought put into making it possible for those of us who are in the trenches and fighting those battles to continue to fight them. The primary care workforce is something that is of value to any community, and is, I think, that part of the workforce that is going to be able to answer this. That element that Dr. Friedland spoke to, the family entity, can advocate and actually enhance efficiencies of a particular case. That entity sometimes has to be the family physician. That is a key element in all of this, that there has to be that glue which you speak of. And the answer may not be to let Aunt Susie go back to the hospital for treatment of her pneumonia. If the family physician has an understanding of the family, pneumonia is not necessarily a terrible way to go. The answer may not be to send that person back to the hospital for antibiotics mindlessly, but the humane thing may be to let the patient go on to meet his or her maker. That may be a noxious

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concept to many, but these are things that we're going to have to contemplate in a period of limited resources.

SENATOR BYARS: Thank you, Doctor. Let's give our panel a round of applause. Just a wonderful response.

[END RECORDING]