

"HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan"
January 31, 2003
Washington, D.C.

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SECRETARY TOMMY THOMPSON: Let me just start off and thank all of you for coming. I certainly appreciate you on Friday afternoon coming here and hearing about our new innovative program on Medicaid. First, I'd like to introduce my very good friend, Governor Mike Leavitt of Utah, and I want to thank him for coming today. We'll be hearing from him as soon as I get done speaking. For the better part of the past decade, Governor Leavitt and I have been pushing for a real major modernization of the Medicaid Program. We began doing so as Governors. In our roles at the National Governors Association, we pushed many times for Medicaid modernization, at one side our push for welfare reform. In fact, we were reminiscing about it upstairs before we came down. This is once again an opportunity to do something remarkable for states, allow them to have the opportunity to develop a successful program. And we succeeded in passing a bold new program, of course, in welfare reform, called TANF, and states have been remarkably successful and very responsible for making TANF work. Governors again worked with Congress a year later to pass SCHIP, which is another tremendously successful bipartisan proposal, which provides health care to more children. Now, the President himself and Governors throughout the country want to tackle the next pressing task of modernizing Medicaid so states can more effectively provide health care to their low

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income citizens. Most states, as you all know, are facing a budget crisis right now. In fact, the last incident, we recognized that about two-thirds of the states have reduced some benefits for Medicaid. And, of course, Medicaid truly is one of the biggest drivers of state budgets. When it comes to this, a state government facing budget pressure really has little choice to look at Medicaid spending. And under the current matching mechanism, if a state cuts one dollar of its own spending, then they forfeit two dollars in federal funds, which also impacts on the economy. So the time, I believe, is absolutely right to modernize Medicaid, and to strengthen how it works. Simply pouring more money into an outdated system that is not going to provide for better health care, and it's not going to fix states' problems. To the contrary, it's going to put the health coverage of thousands of Americans at risk because states can no longer afford to provide it for their individual citizens. I'm very happy to announce today that President Bush is going to propose a plan to make Medicaid more effective, protect and cover more people, and provide better health care delivery. As a former Governor myself, and, of course, is the fact that President Bush is a former Governor, the President too understands the importance of addressing this matter right now. We believe the plan that we are announcing this afternoon, which is going to be optional to states, so the states don't have to take it--if they want to, and I'm sure

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they will, it's something that Governors, I believe, are going to be very enthusiastic about because it's going to give states the upfront investment but also the flexibility to develop programs in order to meet the needs of their people, and be able to, if they so desire, expand coverage to more people.

The current baseline Medicaid spending for 2004 is almost \$180 billion dollars. It's actually \$176.8 billion from the federal government and \$133 billion from the states, for a total of \$310 billion. To put that in proper perspective, the Medicare proposal and the Medicare law right now is about \$250 billion. The proposal addresses the immediate fiscal needs of the states by increasing current Medicaid spending by the projected 9% growth. Over the next 10 years, we are projecting a 9% growth in Medicaid. But then, what we've done is we've frontloaded the Medicaid spending, and the first year—the fiscal year 2004, the states will receive an additional \$3.25 billion in new money for 2004, and it will add \$12.7 billion over a full 7 years. This upfront investment will help prevent people from losing coverage, while also providing opportunities for our states to extend health care to more Americans as needed.

Along with the money, this plan gives every state complete new flexibility in how to target its resources to better serve its people. States, for example, would have the flexibility in order to expand coverage to the mentally ill, the chronically ill, those with HIV/AIDS, those with substance abuse problems,

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and even childless adults, and they could do so without seeking a federal waiver. States would gain greater flexibility in serving seniors and Americans with disabilities. States could design long term care programs for seniors that actually target benefits to meet their specific needs. And seniors would be able to choose from a greater array of services. And people with disabilities would gain greater freedom to work and live independently without losing any of their health benefits. In addition to the financial investment and the flexibility, the Medicaid modernization option for states puts an emphasis on providing health coverage for entire families, children and their parents. Our studies here have shown that if you provide coverage to the parents, you end up actually covering more children because parents will be more likely to sign up the entire family. That is why many states, and my Wisconsin was the first state to try this with Badger Care, which is the way when we received it from the department, we'd seek waivers under SCHIP to provide coverage to parents as well as children. And it's going to help to get more children covered. And we want families to have continuity in their care, to be covered, if possible, under the same health plans with the same doctors and services. Often, low income parents and their children can be a part of several different health plans, each with its own rules and doctors and services. Under this new flexibility, states will be able to develop it so that it will be one doctor

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or the same clinic or the same hospital for all the family.

It's important to note that we are also providing this new option to states while maintaining the mandatory coverage for the mandatory populations, for our most vulnerable populations, and requiring a maintenance of effort, so states continue to invest and maintain their commitment to health care. But in that contribution, under the current law states have to take into consideration their baseline when they decide to submit their state health plans, and they have to increase their allotment in order to get their federal match by increasing the amount of money for population increases, for usage, and for the increase in medical costs. And in the new plan, if they take it, states will only have to put in the additional amount of money for the inflationary amount of medical costs. So it's actually going to be a reduction in expenditures for the states. They're going to get more flexibility, less money out of their treasury, and more money coming in from the federal government. And what gives us confidence that this Medicaid option is the right direction to take is that it's based on other successful models, particularly the SCHIP Program. This program is taking the principles of SCHIP and applying them throughout Medicaid. With SCHIP and welfare reform, Washington was able to give states more flexibility to provide better and more cost effective care, and many of you have covered those reforms and wrote about their successes. Now we need to apply

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those same innovative principles and ideas to Medicaid. The bottom line is that Medicaid is outdated. It's inefficient. Its spiraling costs and straitjacket rules are forcing states into no-win situations, where they need to reduce coverage and have little opportunity to expand coverage. And simply throwing money at the problem will not fix the problem, and Governors recognize this. We need an innovative new option for states with a flexibility to use Medicaid's resources to provide quality coverage to as many people in need as possible and to be able to do so in a very efficient and cost effective manner. We believe the President's plan accomplishes all of our goals. I've been consulting throughout the year with Governor Leavitt, as well as other Governors from throughout the country, as we work to finalize our plan, and I will continue to do so--I just got done on a teleconference with the NGA Executive Committee--and I've been very pleased with the response that we've had. I believe the more Governors understand this plan, the more excited they will become about it. And many of you have known me quite a while, and we've talked quite a bit about Medicaid, as well as state health care, over the years, and you know how aggressive I was on these issues as a Governor. I can tell you enthusiastically that if I were still a Governor, I would jump--I would absolutely jump at an option like this. I would take it and run with it, and I know Governors like Mike Leavitt have already begun running with innovations to Medicaid, and

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really, they're doing a wonderful job. We want to make it easier and more effective for great Governors like Mike Leavitt to provide the health care for their citizens. We certainly hope that our partners with the House and the Senate will want to build on the bipartisan success of SCHIP, as well as TANF, and now go into Medicaid and make it a more effective program for the low income Americans we all want to serve. We will work with all of our state and federal partners to improve Medicaid. Now it's my privilege to introduce Governor Mike Leavitt for some of his perspectives on this plan, as well as on Medicaid in general. And then we will open it up for questions, and I have Tom Scully and Dennis Smith from CMS here to fill in more details of the plan as we go along. So with that, please give a big welcome to, I think, just one of the outstanding Governors in America today, Mike Leavitt.

GOVERNOR MIKE LEAVITT: Thank you. It is a privilege to be here with Secretary Thompson. As he indicated, over the course of many years, we have worked together on this issue of Medicaid. It is not a surprise nor is it new information that the states are in a demanding time. We are working through the most significant drop in state revenues since World War II. A unique capacity, a unique role of government, a difference in the way government works than the private sector, is that during a period like this, many enterprises scale back because they have fewer customers; in government, we have more

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customers during a period like this. We have more who have needs for health care. We have more who are displaced because of their employment. We have more who find themselves in substance abuse. It is a time when there is literally more demand but fewer dollars. This is a smart approach, and I am here today to speak on what I believe will be a universal chorus among Governors. What the states are asking for most of all during this period are the tools that we need to solve our own challenges. Medicaid is very clearly the most rapidly growing portion of state government budgets. If I could just give you one sense from my own state. We will operate the year 2004 on substantially less money than we operated government on in the year 2000. Four years will have passed; we will have had an increase in our population of over 7-1/2%; and we'll operate on fewer dollars than we did in the year 2000. So again, more demands, fewer dollars. In June of last year, the Secretary granted a waiver to our state that used flexibility similar to what is being proposed in this legislation. It allowed us to construct a benefit package among a segment of our population very similar to the benefit package that I have for my family through state government. It produced a costs savings because of the way we're able to administer it and because of the benefit structure, and we have used that savings to expand health care to a large and significant group of Utahans who work sometimes one, sometimes two, sometimes three

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jobs but are not able to afford health care. In other words, we have been providing health care to those who have no jobs, but we've not been able to help, because of the constraints of our resources, those who are working but simply not able to afford it. Using the savings, we're now able to expand that to a larger group of people. This is about protecting access during difficult times. I want to repeat that. This is about protecting access for the most vulnerable during difficult times. This is the kind of flexibility that states need. This is the kind of innovation that will be required of states to meet this difficult financial period to serve our citizens, and I'd like to thank the President and Secretary Thompson for both an opportunity to speak about it today, but we look forward to implementing it and work with the Congress to ensure that it can be done. Thank you.

SECRETARY TOMMY THOMPSON: Thanks, Governor Leavitt, and now we'll open up it for questions. Yes.

MALE VOICE: (unintelligible) have expanded their coverage and they're now straining under the roles of taking care of all these people. Does this mean they'll get additional money above what was (unintelligible) in their additional waiver?

SECRETARY TOMMY THOMPSON: If they go into the program, yes, they will get a portion of that \$3.25 billion in fiscal year 2004, and they will also be able, if they're in the program, they will be able to get a reduction in their costs of

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continuing in the program of I don't know how many dollars—I'd have to figure it out, but they will get a reduction and they will get more flexibility, and they can help to redesign their program. What we're going to do is we're going to—right now, we send out checks in quarterly installments in four programs, SCHIP, Medicaid, and disproportionate use, and we also put out a check for management. And we're going to reduce that now into two checks, one for acute care and one for long term care. And you'll have transferability up to 10% from one program to another, and you will also be able to have up to 15% of the dollars deducted for management. So, you're going to be able to have this—and Tennessee will be able to, if they want to go into the program—I want to reiterate that this is a voluntary program, and so if any state wants to, they can go into it and they will get the enhanced match up front for 7 years, and they will also be able to get a reduction and allow the flexibility to design the program. We will not touch the mandatory population. There is roughly across America one-third of the population that is the optional population. But the options take up about two-thirds of the cost. So states will be able to really have a great opportunity to be able to redesign a program, make it cost effective, and usually be able to expand the program to people that need it, like Governor Leavitt has done in Utah. Yes?

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FEMALE VOICE: Mr. Secretary, the (unintelligible) of the Red Cross, right now is urging the use of matched blood only in an emergency because of mysterious white specks that they found in the blood. What have you been told about this particular situation, and how vulnerable is are blood supply?

SECRETARY TOMMY THOMPSON: I'm sorry I didn't hear it, but are you talking about the blood supply?

FEMALE VOICE: Yes.

SECRETARY TOMMY THOMPSON: We are putting out a tremendous public relations informational program in order to get more people to come in and contribute, and we're trying to get the federal government also to get more of the federal employees involved. We're trying many different ways to do it. We're working closely with the Red Cross and with the independent blood centers, but I've got to tell you—and hopefully you can help us by getting the information out—that we need more donors.

FEMALE VOICE: What I was just asking you was, there is a problem in Georgia right now with the blood supply.

SECRETARY TOMMY THOMPSON: In Georgia?

FEMALE VOICE: In Georgia.

SECRETARY TOMMY THOMPSON: I didn't know about that.

MALE VOICE: The American Red Cross put out a quarantine on blood because they've seen something suspicious in the blood in Georgia. Has your office heard anything about this?

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SECRETARY TOMMY THOMPSON: I haven't been informed before I came down here. I'll look into it and get back to you this afternoon. I'm sorry, I didn't hear you. I apologize.

MALE VOICE: Could you just clarify two things? Is the \$12.7 billion for 7 years—is that up front? Or is the 3.25?

SECRETARY TOMMY THOMPSON: 3.25. Each year will be a different one. It totals up collectively over the 7 years to \$12.75 billion. And the first year, it equates--if I can give you an approximation, it equates to about a 2% increase on the FMAP, which is what states were asking for. But it is not across the board, but this first year it equates to that. I can give you a rundown of each year what the increases would be for the first 7 years.

MALE VOICE: And also, is the money that the President set aside for transitioning from institutional care to community living, is that part of that fund or is that a separate (unintelligible)?

SECRETARY TOMMY THOMPSON: That's separate.

FEMALE VOICE: Mr. Secretary, prescription drugs are one of the fastest growing costs within Medicaid. Are there any tools in this particular toolbox that you're holding up today that would help states address the rising costs of prescription drugs?

SECRETARY TOMMY THOMPSON: Well, not directly, because that's the beauty of this plan. We're going to leave it up to the states. And as you know, the State of Florida entered into a

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very exciting program with one of the pharmaceutical companies, and they have been able to hold down their costs. We have put out and granted several Pharmacy Plus waivers, which have been very helpful to states like Illinois. And we're hoping that states like Utah—I'm not singling out Utah, but since the Governor's here—Governors like Mike Leavitt will take a look at Pharmacy Plus, be able to put that into their program like Illinois has, and maybe to take a look at Florida's program. We're going to be very aggressive in getting out information to all the Governors, what each state is doing, in order to pass the information. And what we're hoping for--and I'm confident, knowing these Governors, that they're going to come up with some real exciting innovative ideas, and we'll take the best, and we'll package them and get them out to other states, so it will be helpful in states coming up with the best program.

Yes?

FEMALE VOICE: What will be the kind of flexibility that states could exercise for the optional population? Could they change the cost sharing range?

SECRETARY TOMMY THOMPSON: Cost sharing, co-pays.

FEMALE VOICE: ...the benefit package? What will be the things that they could pick?

SECRETARY TOMMY THOMPSON: Benefit packages, co-pays. In my home state of Wisconsin, what used to really cause me problems is, is under the Medicaid rules and regulations, you have to

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provide—any time you give optional service or any time you put anything into the Medicaid Program, it has to be uniform throughout the state. When you have a state as diverse and as large as my home state of Wisconsin, which is true in so many states, there are some places in the states, it's very difficult and very financially costly, almost prohibitive, to provide those services, but you have to. Once you start it in one place, which may be good for Milwaukee but may be extremely costly for Superior, which is way up in the northern part of the region. It allows states to be able to come up with a program that they could allow for the adjustment in geography and have that centered. They could also require a co-pay on drugs, co-pay on optional service. They could put in an expanded coverage for more people, allow parents to be able to enroll with their children and still qualify for the SCHIP, which they can't right now except for those states that have waivers. All of these things are just off the top of my head that we could hopefully do. But Governor Leavitt did something which was quite unique, and he got criticized, and I got criticized for giving him a waiver. But he took a targeted group and reduced their benefits to the same benefit level that he was getting from the state on his health insurance and what the state employees were getting. So it still was a really good program; it was just the same program that all the state employees in Utah were getting, and he was able to take that

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pot of money that he was able to save and expand the coverage so the working poor were able to get insurance coverage. You've heard him tell you that it's been extremely successful. So tens of thousands more people got it just because he was able to make that adjustment. And he got criticized for doing it out here. Back home, he was a hero.

FEMALE VOICE: First of all, would there be any limits at all for the optional populations on what people or what benefits could be part of this program? Or will states have complete flexibility to decide who is covered and who isn't covered?

SECRETARY TOMMY THOMPSON: Complete flexibility.

FEMALE VOICE: So if they wanted to--I don't know necessarily why they would, but let's say they wanted to cover people who were a certain income level in one city but at a different income level in another city. Or certain benefits in different states, I'm sure.

SECRETARY TOMMY THOMPSON: There's going to be complete flexibility.

FEMALE VOICE: And is it still--

SECRETARY TOMMY THOMPSON: But the mandatory population will still be covered; it's just on the optional population. But see, right now, the states could actually do that by just eliminating. So instead of eliminating, we're going to give them the flexibility to continue to cover them but try new ideas.

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FEMALE VOICE: And critics of this approach, as I'm sure you know—

SECRETARY TOMMY THOMPSON: I haven't heard of any criticism except from you so far.

FEMALE VOICE: Well, I'm sure they will make sure you--

SECRETARY TOMMY THOMPSON: I'm sure they will. But I want to tell you, I have discussed it with some Democratic Senators this morning. I talked to some Democratic staff people. I talked to a bipartisan group of Governors before I came down. And at this point in time, everybody was extremely enthusiastic about it. I can't imagine why you'd find fault with it because what it does is, it gives you flexibility; it gives you more money up front; and reduces your (unintelligible). How can you (unintelligible)?

FEMALE VOICE: What some people say, though, is that what states are really looking to do, because they're in such tight financial times right now, is that they're looking to cut their overall costs and what will ultimately happen is that—

SECRETARY TOMMY THOMPSON: And that's what they're doing.

FEMALE VOICE: ...and that this is what will continue to happen with this proposal. It will cut benefits and cut populations rather than expand because they simply can't afford it.

SECRETARY TOMMY THOMPSON: Well, that's what's happening right now. Two-thirds of the states, and growing each day, are cutting programs right now, and they will continue to do so

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with the optional populations. What we're trying to do is to stem the tide of the cuts and give them the flexibility so they'll be able to allow a continuation of it, like Governor Leavitt did. He was able to restructure his program through a waiver. Now they won't have to have a waiver. They can restructure their program and still provide the services, and hopefully not reduce the people that are being covered.

GOVERNOR MIKE LEAVITT: We have expanded our Medicaid population over the course of the last 10 years, and we have opted, for example, to add the blind, aged, and disabled as a population. And we've expanded a number of areas, and have done it as a part of the deliberate task to expand health care access to our population. Now, we're in a very difficult budget situation. You look at every piece of my budget. It's a negative, negative, negative, negative, negative, except for one category, and that's Medicaid, and it's a big positive in terms of the actual dollars. As I begin to manage, and as our state begins to manage that dilemma, the way the program has been structured in the past, the options that I have as a manager are very limited. I can do one of two things, essentially. I can take off an entire population, and the last one in, which some people could argue would be the first one out, would be the blind, aged, and disabled. Now, I simply think that's an unacceptable choice for us to take away that entire optional population as a means of being able to deal

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with this. The other option I have is to reduce an entire category of benefits. Now, most of our Medicaid population has prescription drug coverage now. We can take it away, but we don't want to. We want to find something other than taking an optional population like blind, aging, and disabled who very clearly, during a time like this, need the help, or a critical optional benefit like prescription drugs that we now provide, there's got to be a better way. And what the Secretary is saying is, we're going to give to you the same tool that any private sector manager would have during a difficult time, you can find ways to take the same dollars and protect the access that we have provided. This is about protecting access to critical groups to very important benefits. And if we don't have something like this—this isn't a what if; this is happening in 36 states across the country. They have already had to do what I suggested—take away a population or take away some benefit. What the Secretary is proposing is a means by which we can protect access to the most vulnerable populations in our society.

MALE VOICE: Just to add one other piece on this again, the flexibility that we're talking about, a lot of that is present in the SCHIP program now. So, in terms of the things that states might be able to do under the new program, they have that flexibility in SCHIP today. And again, I think also, as Governor Leavitt emphasized, talking about what states are

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doing now, what they already did last year, and what they're contemplating in this year's budget—those things are real now, and if we don't do something, they're going to be even worse in the future.

FEMALE VOICE: (unintelligible)

SECRETARY TOMMY THOMPSON: Pardon?

FEMALE VOICE: It wouldn't have to be budget control?

TOMMY THOMPSON: Budget control over 10 years from the federal government. We're frontloading for 7 years, with a reduction 8th, 9th, and 10th. It would be fiscal year 2011, fiscal year 2012, 2013. And I'm not going to be here to solve that problem.

FEMALE VOICE: Will it allow the federal government over time to take these costs (unintelligible)?

SECRETARY TOMMY THOMPSON: Pardon?

FEMALE VOICE: Will the federal government no longer be able to cut its tax rate?

TOMMY THOMPSON: No.

FEMALE VOICE: It's not reducing the federal contribution?

SECRETARY TOMMY THOMPSON: No, it's not. What I said it was going to do in the 8th, 9th, and 10th, is the plane's going up 9%. In the 8th, 9th, and 10th, it will be probably going up at 5% or 6% to make up for the new \$12.75 billion that's going to be advanced in 7 years.

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FEMALE VOICE: I was wondering if Governor Leavitt was going to give some examples of things he might want to do under this increased flexibility.

GOVERNOR MIKE LEAVITT: I will use an example of things we have done under similar flexibility granted in some cases. Let me use the SCHIP as an example. Under SCHIP, one of the flexibilities that was built into that program wisely was the capacity for states either to adopt the Medicaid Program or to develop their own benefit structure. We opted to develop our own benefit structure, and again we patterned it after the program that my children have, with some additions. By using that and administering it in a way independent of the Medicaid Program, we were able to include more than one-third more children because the costs were lower and the administrative costs were lower. With all due respect to all of those in the audience who may be administrators of Medicaid, may I say it is not the most efficient program that a Governor to come up with. And it is not the best way, in my judgment, to deliver health care to the masses. But nevertheless, it is a program, and this flexibility would allow us to protect that (unintelligible). So SCHIP is going to get a hird more children we're able to protect because we had that flexibility. I mentioned earlier, it's not so much what we would do, it's what we won't have to do. This is about protecting the blind, aged and disabled in our state by adopting a very basic

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philosophy. During a difficult time, it's better to have everyone have basic health care than a few to have all the health care. And what's being proposed here is that we adopt a philosophy that allows us to protect access to literally millions of people who will lose it because there simply aren't dollars to pay for it, and the states don't have the flexibility at this moment to protect their access. And I believe there are Governors in every state who want to protect access, but currently we don't have the tools. This provides it.

SECRETARY TOMMY THOMPSON: Just to give you some ideas. You know, we had Badger Care back in Wisconsin. You have heard of Mike Leavitt's Utah Care. Badger Care allowed for parents to sign up for health care insurance at the same as their children, which the law did not allow. It allows for money to follow the individual, so the person could have the money and stay in his or her own home instead of going to an institution. There is a program in Arkansas in which money is given to the individual recipient to purchase medical care, and they've been able to save a lot of money. Cash and Counseling, it's called. Just some of those ideas are out there that could be very helpful. We're going to take a group of states that have done some innovative things and put them together in a package, and send them out to other Governors. And other Governors like Mike Leavitt are very innovative and come up with their own.

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But some Governors may be a little bit bashful because they're new Governors and haven't tried it. We'll send out ideas for them to look at and see if they want to adopt them. Yes, ma'am?

FEMALE VOICE: Mr. Secretary, could you say a little more about going from the four checks to the two blank checks and what the advantages of that are?

SECRETARY TOMMY THOMPSON: Yes. The advantage is, is what we want to do, is we want states to focus on acute care and long term care. Long term care is the big driver, as far as costs right now, and because our population is aging. And we want to make sure that states address that population, and come up with innovative ways in which they might be able to handle that population. Instead of just putting them into a nursing home, an institution, allow the opportunity for states to give vouchers or give cash to an individual to stay in his or her own home instead of going to a nursing home. That, we think, would save lots of dollars and give a better quality of life for those individuals. That's just one idea. And so, the acute care is not growing as rapidly, and we're also going to allow for the transferability of 10% of the money from acute care to long term care or vice versa, if the state needs it. So we're give them more flexibility. But what we're expecting from the state, which is, if they're going to go into this, they're going to have focus on two populations instead of four

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different areas—instead of three actually, because the management fee is just a check to pay for the costs. But what we want them to do is look at the acute care and then look at the long term care, and that's really the only requirement we're putting in here basically for the states. Yes, Robert?

MALE VOICE: The TANF law said there was no individual entitlement to TANF. The SCHIP law said there was no individual entitlement to SCHIP. Would this proposal affect the entitlement for the optional?

SECRETARY TOMMY THOMPSON: For the optional, it will.

MALE VOICE: How would it affect it?

SECRETARY TOMMY THOMPSON: Well, the fact that it gives the state the flexibility and allows them to have different kinds of payments. There's no entitlement for the optional people anyway. The states can change that as they so desire. That's what Governor Leavitt said. You can cut out a whole group of people.

MALE VOICE: The spending (unintelligible) would go down. How could that happen?

SECRETARY TOMMY THOMPSON: Well, it can happen just the same way that Governor Leavitt has indicated. He was able to save enough money so he could cover, what? An additional million people?

GOVERNOR MIKE LEAVITT: It wasn't quite that many, but it was a lot.

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SECRETARY TOMMY THOMPSON: You save it by redesigning, Robert, the health benefit package. You save money by having co-payers. You save money by not having to require the same uniformity of coverage in every class of the population. You save money, hopefully, by allowing people to stay in their own homes instead of going to an institution, a nursing home. Many different ways that states are going to be able to, I think and I hope and I know, are going to be save some money. Yes?

MALE VOICE: Through the waiver program, the federal government had a large say in what states were allowed to do or not to do with their Medicaid Programs. Without the need to get a waiver, it sounds like you folks are giving the states carte blanche to do whatever they want. Is there a baseline?

SECRETARY TOMMY THOMPSON: Carte blanche in the optional populations they have right now. But not for the mandatory population. We still will require the coverage for the mandatory populations.

MALE VOICE: (unintelligible) even including the mandatory populations (unintelligible).

SECRETARY TOMMY THOMPSON: Families in mandatory populations-- families who meet the state's old AFDC standards, Section 1931, a certain individual with disabilities, such as SSI recipients and those who lose SSI due to earnings from work; infants born to Medicaid eligible pregnant women; children under the age of 6, and pregnant women with family income less than 133% of

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poverty; children aged 6 to 18 with family income less than 100% of poverty; recipients of adoption assistance of foster care under Title 4(e); certain protective groups who may keep Medicaid for a period of time, such as transitional Medicaid going into welfare; and certain low income Medicaid beneficiaries, the dual eligibles. Yes?

MALE VOICE: A lot of people are saying that a lot of financial (unintelligible) Medicaid are not within Medicaid, they're state funded, so they have been reduced by the economy and by (unintelligible).

SECRETARY TOMMY THOMPSON: This is true.

MALE VOICE: And so, what's plan B? If this flexibility can't save the Medicaid Program, what is plan B for the states?

SECRETARY TOMMY THOMPSON: The states are going to either—I am quite confident most states will take this opportunity because there are three main drivers that are going to benefit the states. First, the flexibility; second, the additional money up front; and third, less expenditures in order to get the match. So it's going to be very helpful. The next option, if this does not work, is states are going to have to cut out a whole group, a whole population, a whole classification, or reduce the costs by making dramatic cuts in the Medicaid population.

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MALE VOICE: Does the plan take into account underinsured? I mean underinsured people are a problem, having enough coverage (unintelligible).

SECRETARY TOMMY THOMPSON: Well, the beauty of this plan is it's going to give the states the flexibility to be able to develop exactly a program for as many of their populations they possibly can afford. And hopefully, it's going to give them the opportunity not to cut a whole group, a whole classification, a whole class of people that now need coverage or might need coverage.

FEMALE VOICE: Is the extra money that states get just added to the match, or is it just a chunk of--?

SECRETARY TOMMY THOMPSON: Yes, yes. You're going up about 9%. The first year would be an additional probably 3-1/2%.

FEMALE VOICE: And what does it take for a state to be participating in this program? In other words, to say that they're in it, do they have to make--if they make just one small little change to their program are they in it, and then they get the extra money?

SECRETARY TOMMY THOMPSON: No, because if they want to go into it, they'll let us know. We haven't actually set up the mechanics of it, but basically they're going to agree that they're going to collapse their programs into two streams, one acute care and one long term care, and that they will set up their own programs. It's going to be very easy to get into,

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and I can't imagine a state that would not get into it, but we're going to make it voluntary just so that states are not forced into it. I can't imagine a state not taking the deal, can you?

FEMALE VOICE: As a (unintelligible) on that, are they required to make a (unintelligible) change, or they just can step into (unintelligible)?

SECRETARY TOMMY THOMPSON: It's really going to be left up to them. We're going to leave it up to the states.

FEMALE VOICE: Then they aren't required to change the program, in terms of structural or—

SECRETARY TOMMY THOMPSON: They don't have to, but they're going to have to develop some changes because they're going to have to make some sort of way to have acute care taken of and the long term care. So that (unintelligible) on itself is a (unintelligible) change for them to get into the program. But I can't imagine, knowing these Governors, that they will not, especially with the financial problems that they're having—I'm not sure, but it's over 43 states, isn't it, Mike, that have financial problems?

GOVERNOR MIKE LEAVITT: 46.

SECRETARY TOMMY THOMPSON: 46 have financial problems. I can't imagine a state that's having financial problems, and Governor Leavitt will tell you that Medicaid is one of the driving forces; it happens to be one of the fastest growing

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expenditures at the state level, that they would not use this to redesign their program.

MALE VOICE: You mentioned Florida and their prescription drug negotiating program. Other states have programs similar—Michigan--there are a bunch of other states that are controversial. Do you think that these Medicaid formulary negotiating programs are a good example of states using flexibility to save money, or do they unfairly restrict poor people's access to prescription drugs?

SECRETARY TOMMY THOMPSON: I look at it as a way for the states to continue to offer the pharmaceutical coverages. If they don't have this kind of negotiating power and ability to do it, they're going to drop the coverage for the optional population. You want to add something to that, Tom?

TOM SCULLY: I just want to add, in talking about the structure (I guess Amy did). One example here, as some of you know, we spent an enormous amount of time with states who have many pots of money, including upper payment limits, disproportionate share payments. We spent an enormous amount of time with California, working on something the last couple of months. What we're talking about doing is taking the state's existing level of effort and increasing it at exactly the same level at what the federal payment is plus a couple of percent, giving the state the flexibility to use that. So there wouldn't be any more finite stream of money from Medicaid DSH or Medicaid

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UPL, which currently takes an enormous amount of management time between the states and us as far as figuring out those cash flows. Are we going to give them exactly what we have, plus their existing baseline, plus a little more, and give them the flexibility to use it without having to go through 8 million hoops when they jump through it to manage their program. I think the states are going to find this much simpler. They're going to get more money, much less hassle on how they get it, and the existing rules would basically untie a lot of their, I think, more creative energy to use their programs and come up with new ideas to run them that they can't do right now, and prescription drugs is certainly one of them.

MALE VOICE: Does this assume (unintelligible) some of the state funding requirements because they're not built into the waiver programs?

MALE VOICE: I couldn't hear your question.

MALE VOICE: Does this eliminate some of the state funding matching programs that are now built into the waiver programs?

MALE VOICE: No. Whatever their existing baseline is continued.

SECRETARY TOMMY THOMPSON: It's not going to limit it. It's just that the increase each year, that a state has to submit a state health plan, and we take a look at that, and they have to get an increase—we charge them an increase for the inflationary cost increase of medical coverage, and then the state has to

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put into that equation population increase and utilization.

And we're now saying we're going to give you a better break.

You're not going to have to put in your population growth or your utilization when you figure out your state matching part.

Okay?

MALE VOICE: Can you give us the nonmandatory population, who that encompasses? And also, what is the average amount of time it takes for a state to get a waiver request granted?

SECRETARY TOMMY THOMPSON: Well, the optional population, individuals in mandatory categories with incomes higher than the mandatory levels, including families at higher income levels than the former AFDC standards; certain caretaker relatives; children covered by Title 21; low income aged and disabled; pregnant women and infants between 133% and 185% of poverty; 19 and 21-year-olds who meet AFDC plan requirements; noninstitutionalized elderly or disabled made eligible through home and community based service waivers; medically needy individuals whose medical costs, when deducted from income, caused them to otherwise meet eligibility standards; transitional Medicaid recipients after the initial mandatory period. And as far as waivers, when we came in to this, when the Administration started and I took over, we had waivers going back to 1986, and now we have caught all of those waivers up in the last two years. And we are current with our waivers, and now we try to get waivers done in 60 to 90 days, and that's

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been the average. Sometimes they're longer because we negotiate back and forth with the states, but it's moving forward. This gentleman has done an excellent job of getting it (unintelligible).

TOM SCULLY: If I could add just one piece, and again, these are the broadest mandatory and optional groups, and we'd be happy to run through every single one. There are at least 50 ways, different ways to become eligible for Medicaid. These are the largest groups, but there are many more. Part of the other message, though, is there are people that do not meet any of these standards, that cannot become eligible for Medicaid. Childless adults is one of the biggest examples. You can be under a hundred percent of poverty and a childless adult, and still not be able to qualify for Medicaid. Part of this is to be able to give that other flexibility. Again, states have had to do—in order to extend benefits to people who do not meet the categorical eligibility groups, then you have to go through the waiver in order to extend those benefits. But overall, about a third—roughly a third of the population are there at the states' option, because they have taken the leadership to extend benefits to them.

MALE VOICE: You say one-third?

TOM SCULLY: Roughly a third. Two-thirds of the Medicaid spending for mandatorics and optionals and optional

services—two-thirds of the spending are there because the states elected to provide those benefits.

SECRETARY TOMMY THOMPSON: Yes?

MALE VOICE: If you eliminate the DSH payments, aren't you putting to risk the hospitals that serve our portion of the uninsured?

MALE VOICE: No. The money's still there.

MALE VOICE: The disproportionate share of money goes to the state for distribution essentially as the state wishes. It's the state that qualifies for the DSH payments, and the money's still there. All we're essentially doing is taking, for example, to give you another example, we spent an enormous amount of time with Missouri, going through a very comprehensive negotiation for a year. Most of that would have been unnecessary under this. We would have said, here's the money you've had this year. It's going to grow at the existing rate. Your contribution would be the same. The federal contribution on the front end would grow to give you more flexibility. So, the DSH money's still there. It's just not under the same money stream.

MALE VOICE: Again, the idea is that the money's all there, as some states have already asked us to do, is to convert it from disproportionate share specific to hospitals, to be able to use the money for other purposes, to give health care coverage to individuals directly rather than to go to the hospitals. But

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if the hospital still wants to use every single dime, giving it to disproportionate share hospitals, they absolutely will be able to do that.

FEMALE VOICE: And will all of this require legislation, or can some of it be done administratively, and what's it like on the Hill?

SECRETARY TOMMY THOMPSON: Very good question. It requires legislation, and we can't get this legislation passed unless the Governors are enthusiastically behind it and push it. And so, we're hopeful that we have designed a program with the Governors and for the Governors that they will embrace and will talk to their elected representatives to Congress, and if they do that, we have a good chance of passing it. I think that most Governors are going to be very appreciative and very enthusiastic about these changes, and will be contacting their Congressional representatives.

MALE VOICE: (unintelligible) the waiver process for states that sign up. Is it (unintelligible) waivers at all since they have (unintelligible)

SECRETARY TOMMY THOMPSON: All of the other areas that we will have waivers on.

MALE VOICE: And if this requires statutory changes to access Medicaid prescription drug formularies in the states, pharmaceutical companies have filed lawsuits and sued over those because they say the Medicaid statute does not permit

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Medicaid to make formularies that restrict some drugs and not others. Does this make any changes in the statute that would obviate that, that would provide that flexibility in the law, or does it not address that?

SECRETARY TOMMY THOMPSON: It will not address it. Would you answer?

MALE VOICE: I was just going to say, again, there are lots of details that need to be done as legislation moves forward. That's an issue that through discussions with the Governors and through the Congress and consultations to deal with an issue like that.

MALE VOICE: One thing. State by state, if we want to reduce the waiver process, the bulk of it state by state we can do. The main difference is we can't change the FMAP. But the main difference, it can't be done without legislative handling of the money. So if we wanted to go through state by state, and Governor Leavitt has sent all the other Governors by state by state, the bulk of this we could do now, but we can't have the \$3.25 billion or it's basically cutting through a lot of the process without (unintelligible).

SECRETARY TOMMY THOMPSON: You couldn't reduce the expenditure for the readjustment. Yes?

FEMALE VOICE: Have you spoken with Chairman Tauzin and Grassley on prospects with moving legislation this year and (unintelligible) this proposal?

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SECRETARY TOMMY THOMPSON: I have talked to Congressman Tauzin, and I placed a call to Senator Grassley, but his staff was briefed—Senator Grassley's staff was briefed this morning.

FEMALE VOICE: (unintelligible)

SECRETARY TOMMY THOMPSON: Support. He certainly wants to talk to his Governor. Every one of these individuals will want to talk to their Governors, and that's why it's so important to have the Governors behind it. Did you want to say something, Mike, about that?

MALE VOICE: Could you walk us through maybe the first two or three years, what it would equate to in the FMAP increase. You said you had some kind of numbers.

SECRETARY TOMMY THOMPSON: I can get you those numbers. I don't have it off the top of my head. The first year is 3 billion 250 million dollars, and increase, and that equates to a little over 2% increase on the FMAP.

FEMALE VOICE: 2% in points?

SECRETARY TOMMY THOMPSON: 2% in points.

MALE VOICE: In '04?

SECRETARY TOMMY THOMPSON: In '04. Yes?

MALE VOICE: You said there's no individual entitlement now for the optional population. But isn't it true that states, if they do decide to cover optional, do get the federal match (unintelligible)?

SECRETARY TOMMY THOMPSON: Yes.

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MALE VOICE: And it sounds like that would not be true under your proposal if they went above the amounts you're allocating, so essentially it would be capped. And wouldn't this become a particular problem in years 8, 9, and 10, when presumably, to keep it 10-year budget neutral for the feds, the states would have to be getting less money than they would have otherwise?

SECRETARY TOMMY THOMPSON: No. In years 8, 9, and 10, the states would get less money. Not less money than they got the year before. The growth will not be as high.

MALE VOICE: Less money than under current—

SECRETARY TOMMY THOMPSON: Under current law because under current law is a steady plane of about 9% increase, and in the year it's going to be above that—the plane; and then year 8, 9, and 10, the plane will be below the 9% growth.

MALE VOICE: So what happens under your proposal if a state wanted to cover a large percentage of its optional population, but that decision would take them above the amounts that are allocated in your program? Would it then be capped and they wouldn't be able to do that?

SECRETARY TOMMY THOMPSON: No, it's not going to be capped.

MALE VOICE: Again, part of this, looking over a 10-year period of time, is an assumption that you have time to improve your service delivery system to be able to avoid doing any of the cuts that the states are now faced with now. Medicaid, you have huge over-utilization; you have huge underutilization,

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part of it because the way service delivery system is delivered now. This gives the states the time to improve their service delivery in order to be able to improve the way care is provided, especially again, to people with disabilities. If you are helping them to stay in their own homes, which is what they want to do, and stay out of an institution, which is what they want to do, that also saves money. So states making those reforms today will save the money in the long term, so you're not going to be faced with this either/or choice that they are faced with now.

SECRETARY TOMMY THOMPSON: One more question.

MALE VOICE: Mr. Secretary, I've just got a question. You've talked about expanding coverage, saving money, it seems to me that (unintelligible) then to pay for this, you have to reduce benefits, so what kinds of benefits would be lost?

MALE VOICE: That's not true.

SECRETARY TOMMY THOMPSON: That's not true, but I don't know what benefits. You have co-pays? You could have co-pays.

MALE VOICE: Governor Leavitt talked about having a basic package of health care for all, but some folks wouldn't get all the health care, so who's not getting something under this plan?

MALE VOICE: That's not true under mandatory.

MALE VOICE: That would not be true under the mandatories. Optionals are by their very nature optional, and the difficulty

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right now is that the only option is to eliminate them. And we'd like to come up with an approach where we could have some options to keep the options in place. That's really what it boils down to.

SECRETARY TOMMY THOMPSON: Thank you all for coming.

(unintelligible) more information that you request, we'll be more than happy to give it to you.

[END OF RECORDING]