

THE ALLIANCE FOR HEALTH REFORM

MEDICAID 101

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MR. ED HOWARD, ALLIANCE FOR HEALTH REFORM: Well good afternoon and on behalf of the Alliance for Health Reform, Senator Frist, who's are vice chair and Senator Rockefeller who's our chairman welcome to this program on the ABC's of Medicaid. We are very pleased to have the Commission on Medicaid and the Uninsured as a co-sponsor. And I guess I should reveal the interlocking directorates at work here, Jim Tallon, who chairs that commission, is a member in fact of the board of directors of the Alliance so it's all in the family.

I'd like to say congratulations are also in order to those of you who are here. It means you're prudent about signing up in timely way for the most part because we had to cut off registration, I think it was Tuesday, for most of the folks because we wanted avoid fight with the fire marshal about seating capacity of this room. We snuck a few extra chairs in at the last minute, but we hope everybody is as comfortable as they can get without having someplace to write on. We wanted to accommodate as many people as we possibly could.

And that's really just one more reason I'm pleased to announce to all of you that a video Webcast of this briefing is going to be available at least tomorrow, maybe even be sooner than that, through Kaisernetwork.org. There's a flyer in your materials that gives you more information about that. You can even get most of the materials from the kits from that Web site through either direct posting or some links that are there. So, if you know somebody who couldn't attend today or somebody in your state or district office who needs to know about Medicaid, because they do case work on Medicaid, get the substance of this briefing through Kaisernetwork.org.

Now, when Diane Rowland and I decided to include this briefing in our series for the year it was because, kind of castor oil, it was something the congressional staff ought to be interested in so we put it on the roster and low and behold you are interested in it and we're very pleased with the turnout and the level of interest and we're looking forward to a very good session today. It really is important for us to understand what Medicaid is, how it works and it's easy to say why. Let me just take a minute to do that.

First of all, fiscally I mean even in Washington \$170 billion a year, if you count both the state and the federal share, is a fair amount of money to be talking about. And if you look at the CBO baseline projections from last month it looks to me anyway as if total Medicaid spending by the year 2011 is actually higher than the projected Medicare spending in 2011 if you take both the state and the federal shares. That clearly is a program that needs to be examined.

Politically, I don't think anything provokes a state, federal skirmish than one or the other taking one or the other taking steps in Medicaid to gain more control or to shift spending to the other party. So, it's important for your relationships with people in your state as well. And as far as the substance of healthcare is concerned, getting proper health and long-term care to upward of 40 million people a year, among them the most vulnerable among us, is a big deal. Medicaid plays a central role in delivering that care.

So, we know it's important. Unfortunately understanding Medicaid isn't exactly the easiest task in the health policy world. It's complicated. It's often obscure. It's a moving target and perhaps most perplexing it's a different animal in every state. That's why we're so pleased to be able to line up such top-rate experts to respond to your questions today. So, let's get started with that.

We're going to kick off the discussion with Diane Rowland, who is indeed the executive vice president of Kaiser Family Foundation in addition to being the executive director of the Kaiser Commission on Medicaid and the Uninsured. Her academic credentials are impeccable. She's an adjunct faculty member at Johns Hopkins, a leader in health policy and health services research communities. She testifies regularly before Congress about Medicaid, most recently just a week or so ago about prescription drugs and a range of other issues. And today she's going to walk us through the basics of who Medicaid affects and we're very pleased to have you with us. Diane.

MS. DIANE ROWLAND, DIRECTOR KAISER COMMISSION ON MEDICAID AND THE UNINSURED: Thank you and thank you for coming. I don't think Medicaid is quite like castor oil. I think it's a little more complex perhaps than castor oil. I think as we begin today that we have to really bear in mind what this program does. It does very, very different things for different parts of the low-income population and today covers one in 10 non-elderly Americans, but one in five of American children. It's paying for 40 percent of our births nationwide, supplementing Medicare for about six million Medicare beneficiaries, working on ways to improve access for the

low-income population and providing our only real source of public financing for long-term care services, especially in nursing homes.

In its role for these populations, it obviously plays a very different role depending on who you're looking at. For the poor, it covers 37 percent, but it has a long way to go before it reaches all of our poverty population. It covers some people in the hundred to 200 percent of poverty range, but not as many. There the role is much stronger for private employer based insurance. It is predominantly a program today that covers poor children. It does a somewhat better job of covering women than it does men because we cover pregnant women along with their children and single mothers, but we do a much less effectively job in Medicaid of reaching men.

That is because this program has a history that webs it to the welfare programs where coverage as based on being a single parent in a family with dependent children. So, childless adults, both men and women no matter how poor, fall outside of Medicaid's eligibility group. Today coverage has been extended to more and more low-income children regardless of welfare status and regardless of family composition, but we still need to look broader at the coverage of the parents of those children. It also plays a key role for minorities. If you look here, 21 percent of African Americans receive their healthcare coverage today through the Medicaid program.

However, I think the most important slide to remember as you think about the Medicaid program is this summary of Medicaid enrollees and expenditures because while 51 percent of the beneficiaries of the Medicaid program are children, they account for less than 15 percent of the total spending. The role Medicaid plays for low-income elderly and disabled individuals is its predominant spending feature. So that if you look at this slide, you see that the disabled for example account for 17 percent of the beneficiaries on the program and nearly 40 percent of the expenditures.

This is reflected when you look at the distribution of Medicaid costs by the type of service and this figure gives you a very good sense of what is included in the Medicaid benefit package, inpatient hospital care, physician services, prescription drugs, payments to Medicare for beneficiary's premiums and payments to managed-care organizations account for 52.8 percent of Medicaid spending. But long-term care, which Medicaid covers, and most other programs including Medicare do not, accounts for 38.4 percent of total Medicaid spending and includes personal care, home health services, mental health services, especially for the chronologically mentally ill, institutional care for the mentally retarded as well as long-term nursing facility care and these are among the services that are the most costly on a per person basis to Medicaid.

There is also a slice up here that Andy's going to tell you more about, which is called the DSH payments, disproportionate share hospital payments. We separate those out from the benefits because they are not accrued on an individual basis, but are in fact the payments that go to hospitals providing a substantial share of care to low-income Medicaid and uninsured patients and are part of the financing of the program, but not directly related to care for individuals.

If you look at the next slide, I think you can remember quite clearly that we have different populations with different needs on the Medicaid program. Children primarily depend on Medicaid to provide acute care services and they cost on average about \$1,200 per child per year, quite comparable, and in fact somewhat lower, than much of the private insurance costs for children. However, the blind and disabled and the elderly account for a much higher per capita expenditure, over \$9,000 for the blind and disabled, over \$11,000 for the elderly.

If you see in the yellow shading there, that is largely due to the fact that the elderly depend on Medicaid for very expensive nursing home services, institutional care and the disabled have very high health needs, both in the community and some in institutional care, but it is their higher utilization of healthcare services that makes the disabled a particularly expensive group to serve within the Medicaid population.

And that is why, if you look at what has happened over time to Medicaid spending, you see that the growth in spending has not been driven by the expansions of eligibility to more pregnant women and children, the sort of yellow and pink bars at the bottom, but in fact has had a substantial relationship to the growth in the number of disabled people covered by the Medicaid program because when you add people with disabilities, adding one disabled individual at a cost of 9,000, equals about eight children at a cost of 1,000 or more.

Now, when we think about Medicaid's various roles, the one that's most familiar as we deal with the uninsured problem, is its role as a health insurer for low-income families. And here you see that about 37 percent of the poor and 16 percent of the near poor rely on Medicaid as their predominant source of insurance. As people gain income, they tend to have more employer base coverage. We care about getting more people health insurance coverage, especially in the low-income category because we know it makes a difference in their access to care and use of services.

And here you see that when we compare access by those with private insurance, Medicaid and the uninsured among the low-income population, Medicaid does quite well at matching the kinds of the access that you see for the privately insured and substantially improves the chances of gaining care over that of those without insurance. And so over time, Medicaid has expanded dramatically to try and provide broader protection at least to low-income children and some of their parents. Changes in the 1980s, led in part by Christie's former boss, Senator Chafee, Congressman Waxman in the House, helped to broaden coverage for pregnant women and children and has really laid the basis for the enactment later of the Child Health Insurance Program, which is today providing additional coverage to children above the Medicaid eligibility level.

And what's important to remember about these changes is that that way someone becomes eligible for Medicaid depends on two sets of standards, the standards for categories, whether they fit the right category of individual such as being a child instead of being a childless adult, and second whether they match the income standard for that particular group of people. In terms of the changes Congress enacted, there are no federal minimum standards that all states must meet for the income eligibility of pregnant women and children, but that same set of federal standards does not apply to coverage for the parents of those children. They stay both at state option and tied in many states to the former AFDC income eligibility level and they of course do not extend to childless couples.

So when we look at the Medicaid program and who's eligible on the basis of income, you have to think about both the federal requirements and then the state options that build upon on that. And one of the areas that Congress has given states the greatest flexibility to broaden income eligibility is for low-income children with Medicaid and then the subsequent enactment of CHIP many states have now gone, 36 states, to covering children at or above 200 percent of the federal poverty level. Others are moving toward that coverage so that there's a real sense of gaining eligibility for children of higher income levels.

In addition, we've learned a lot through the CHIP and Medicaid implementation of coverage for children about simplifying eligibility standards making the enrollment process more user friendly to try and improve participation in the program. And so we see now for example that 42 states have eliminated the asset test, the resource requirement for trying to determine if in addition to income you have too many holdings that would prohibit you from being on the Medicaid program. All of these steps are ways to simplify and improve eligibility.

But I would remind you that the reason for needing most of these changes is that here we are dealing with a means tested program so you have to prove that you are low-income enough to be eligible for this coverage and these are some of the ways in which states, especially under the welfare rules, used to determine whether you were poor enough for both welfare and eligibility and then Medicaid. Today as Medicaid moves to become more of a health insurer for children some of these steps can be eliminated or simplified to try and make it a more user-friendly health insurance program instead of a means tested welfare program.

Now, there hasn't been as much progress those states under welfare reformed gained some ability to provide more broad-based eligibility income wise for the parents of the children they're covering and other states have used waivers from the federal government to broaden their eligibility as well. So that we're now seeing some progress in trying to move the eligibility of parents to match that of their children, but as you think about Medicaid think first that children have the broadest income eligibility, pregnant women next and then slowly some of the states are adopting broader coverage for the parents of the children.

However, remember as we look at this, that of the 24 ½ million uninsured, low-income populations we still have over half who are adults without the children, who fall outside of Medicaid's reach. They are the crux of our low-income uninsured problem. We have children who are uninsured who could be participating in Medicaid and CHIP and are not. So simplifying enrollment and doing broader outreach to find them could help address that share of the uninsured. And finally broadening coverage for parents that bring parents into coverage with children could help provide broader coverage there. So as we look at the low-income uninsured populations, Medicaid and CHIP together, provide a real mechanism for trying to broaden coverage at least to low-income families.

Within Medicaid, one of the main movements over the past few years for coverage has been to shift from fee-for-service to managed care. Today roughly half of all Medicaid beneficiaries are enrolled in a managed care plan. Those plans vary tremendously across the country. Some are more risk-based HMO type plans. Others are more primary care case management. And it also, as everything in Medicaid, varies tremendously by which states have been most aggressive in implementing managed care. Some states are now moving to implement managed care for the disabled, but not all states have gone in that direction, but that is an increasing trend as we look at coverage in Medicaid.

You have heard undoubtedly about problems with plans dropping out of Medicare and leaving Medicare beneficiaries with difficulty finding access to new plans and new care. There are similar problems in many states in the Medicaid program. So stability of the managed care plans participating is an issue as well as the satisfaction and access to care of the low-income populations served by these plans. We haven't seen a real deterioration over the days of fee-for-service, but we also haven't seen some of the notable improvements that many of the states have hoped to accomplish in improving access to care through the Medicaid program's move to managed care and to medical home.

And finally, you're going to hear a lot about other pieces of Medicaid in the next year that haven't been as much on the radar screen in the past year and that specifically is Medicaid's role for low-income Medicare beneficiaries. As Congress moves to debate a prescription drug benefit for Medicare and moves to look at ways to reform Medicare, one thing to take particular note of is the role that Medicaid plays for six million of Medicare's beneficiaries. Roughly 40 percent of all beneficiaries on the Medicare program have incomes below 200 percent of poverty. This group is therefore in the same range as most of the other low-income individuals served by the Medicaid program and is in fact a group for which Medicaid plays a key role in helping to supplement Medicare benefits providing wrap-around services for things like prescription drugs, providing coverage for long-term care as well as helping to pay the premiums and cost sharing.

And you see here that of Medicare beneficiaries with incomes below a hundred percent of poverty about half of those individuals also have coverage from Medicaid so they are considered dual eligibles. They get Medicare benefits first and then Medicaid wraps around with the more comprehensive services. In addition, some 13 percent of those between 100 and 200 percent of poverty also have Medicaid coverage. Congress has made this coverage available in different tiers and most of these individuals that I've talked about have what we call full Medicaid benefits, which means that they're probably receiving Supplemental Security cash assistance and therefore eligible for a full range of Medicaid benefits or institutionalized in a nursing home where they're getting drugs, wrap-around services, long-term care services if they're in the community in-home services.

But there are also other groups of individuals for whom Medicaid's role is primarily to pay the premium or to assist with the cost sharing under Medicare and these individuals, beginning with the QMB group down, do not get prescription drug coverage or the wrap-around benefit, but they are a fairly small share of that population. And you can study this little chart if you think all of Medicaid is as complicated as this chart, you're right. The

health status of the dual eligibles is something to also bear in mind when you talk about reforming Medicare, the individuals who have Medicaid coverage as well as Medicare are among Medicare's sickest population. They are much likely to be in fair or poor health, to have activity of daily living limitations, which make them eligible for long-term care services and who have suffered stroke, diabetes and other kinds of chronic illnesses. This is a group in great need of prescription drug and large amounts of medical care, which is why you see their per capita cost to Medicaid at over \$10,000 above and beyond any spending that occurred on the Medicare side of the ledger.

Beyond this group, Medicaid also covers individuals with disabilities. Some qualify for Medicare after a two-year waiting period when they become eligible for Social Security Disability payment, but many do not. But those individuals on Supplemental Security income, the cash assistance program for the elderly and disabled, are also then covered by Medicaid. Congress increasingly has been trying to also provide the sustained health benefits to the disability population if they can go back to work. So you now see an increase in the income levels in the availability of coverage from Medicaid for disability patients who are able to go back and work in the workplace.

The expenditures for the disabled are roughly 66 billion. I showed you on the earlier slide what a large share they are and this summarizes the range of services that people with high levels of disability get from the Medicaid program. These are individuals who generally are not going to be able to obtain this kind of service from any private health insurance policy. They are low-income and they are extremely in need of a wide range of services including assisted living and other kinds of aid in the community.

So finally when you look at Medicaid as a purchaser, it's not surprising, given the kinds of expensive services it buys and the kind of substantial healthcare needs of its population that this program continues to grow in spending. Though I would say that, if you look at acute care spending, what you would see is that that has pretty much been an area where states in recent years have been restraining their percentage growth. It's in the prescription drug area where states earn some of the largest cost increases as well as for long-term care. That we've had a situation where restrained growth has been going on in the last few years, but we're now facing new pressures, especially from rising costs for prescription drugs and also for the cost of increasing the quality and improving some of the wage base in the nursing home industry to be competitive in a robust economy.

If you look at and think about the prescription drug coverage, since I know you'll be dealing with this in the Medicare area as well, I just wanted to point out that, of the 14 billion Medicaid spent on prescription drugs in 1998, over

half of that was for the blind and disabled and another quarter for the aged so it is not children and pregnant women whose coverage is causing the prescription drug rise that most states are facing. It is in fact the care of a very disable population.

And finally, Medicaid does provide a critical role in our long-term care safety net. Thirty-eight percent of all spending in the nation on long-term care comes from the Medicaid base and of that Medicaid spends over half of its dollars on nursing homes. So when the need for care in a nursing home, often 20, 30, \$40,000 a year arises, when you think back to the low-income of many of the Medicare beneficiaries, you see the critical role that Medicaid plays as a long-term care safety net for many of our elderly and disabled beneficiaries.

So that's a quick overview of the major features of this program, the multiple parts. I think I'd like to end by emphasizing Ed's opening point that this the nation overview. This varies state-to-state, but these are the core things that Medicaid does in every state. And I'm going to turn to Andy now and have him tell us how it's all paid for.

MR. HOWARD: And while he's getting into position, let me just say a couple of words about Andy. When I worked on the Hill and had a Medicaid question I couldn't answer, it was easy because you could pick up the phone and call Andy Schneider. For two decades, Andy staffed and shaped Medicaid policy as a member of the staff of the House Commerce Subcommittee on Health & the Environment. He now operates his own consulting firm, Medicaid Policy LLC. His knowledge and his insights into this complicated program remain unmatched and we're going to hear, as Diane said, a bit of education today from Andy on the program's financing. Andy, thanks for being with us.

MR. ANDY SCHNEIDER, MEDICAID POLICY LLC: Thank you, Ed, for that tasteful hyperbole. I appreciate it. When I was asked to do this, I was a little reluctant because I knew I had to follow Diane and as you can tell, this is not an easy act to follow. So I want to just try to ratchet down your expectations right now. This is going to be seven minutes on how Medicaid is paid for.

The one thing that does strike you as you sit and watch this presentation is there are a lot of moving parts to this program and 40 million people out there who pretty much can't protect themselves. So as you are thinking through reform proposals just do it carefully and think it all the way through because there's a lot at stake, there's a lot at stake here.

I want to go back to the Medicaid primer for a second, which should be in your packets and this is something that David Rousseau at the Kaiser Commission helped update. On page six so you don't have to take any notes here is basically an outline of what I'm going to talk about. It's titled, "Who Pays for Medicaid?" The first basic point is the costs of Medicaid are shared by the federal government and the states. Now the states can, if they want to, require their localities to put up some of their own general revenue dollars and some states do that.

The second point is that state participation in the Medicaid program is optional. It's not mandatory. There's no constitutional requirement. There's no requirement of the Social Security Act. States are not required to participate in Medicaid. There's no mandate. On average if you look the federal government's contribution to Medicaid and the state contribution to Medicaid, at least 57 percent of program spending is paid for by the federal government on average.

That's going to vary all over the lot from state to state. It's going to vary all over the lot from function to function. The basic rule is something in the Medicaid Statute and Title XIX that's been there since 1965. It's a formula and the fancy name for it is FMAP, Federal Medical Assistance Percentage. Let's just call it the matching rate and that is the formula which describes for each state for every dollar it spends how much in the way of federal dollars it will get to match its expenditures.

And again the basic rule here is the state, if it wants to participate in the program, can draw down federal dollars for allowable expenditures, that is for covered services of the kind that Diane laid out, for eligible individuals, that, the rate that the state chooses to pay, within broad federal guidelines. The formula is tied to the average per capita income in each state, which is generated by the Commerce Department. They look at a three-year average. It's updated annually and there's a floor at 50 cents on the dollar or 50 percent. The range this year and this federal medical assistance percentage is from 50 percent to 77 percent depending on the state.

If you look at page 10 of your primer, you'll see in the second column from the left, you'll see the FMAPs or the federal matching percentages for your state for 1998. They move around a little bit from year to year, not that much. This is generally the order of magnitude that your state is getting for this year. Now there's some exceptions to this matching rate. For example what we've talked about here applies to all services, all this range of services that Medicaid covers except for family planning. In every state, family planning services are reimbursed at 90 cents on the dollar, federal government pays 90 cents on the dollar.

If you look at administrative functions, the general rule is, regardless of the state, the federal government will share in administrative costs at about 50 cents on the dollar. There are some exceptions to that of course. There are to almost everything in Medicaid. Fraud control, if the state has a fraud control unit, as the states are generally required to have, the federal government will pay 75 cents on the dollar. Management information systems are matched 75 percent. Inspections of nursing homes to insure they meet basic quality requirements, those are matched at 75 percent. And the general rule though for administrative expenses is 50 cents across the board.

So what does it mean to have a matching rate like this if you're looking at it from the state's standpoint? Then you'd say well I have a state dollar here and if I want to spend it on Medicaid what does that mean to me in terms of federal revenue coming in? Okay, so if you're a 50 cents state, 50 percent state, you put in a dollar, you get a dollar from the federal government. If you're a 60 percent state, if you put in a dollar, you get \$1.50. If you're a 70 percent state and you put in a dollar, you get \$2.33. If you're a 75 percent state or if you're funding drug control units or nursing home inspections or management information systems for each dollar you put in, you get \$3 from the federal government. Again for each allowable expenditure for an eligible beneficiary for a covered service, the federal government will match according to these statutory formulas. It's an open-ended entitlement program both to the states and to the individuals who meet the statutory criteria for qualifying.

So let's go back to the figures. Again I'm getting a free ride on Diane and her staff, Rachel Garfield, who put these together, but my color commentary here is not necessarily reflective of their views. Let's take a look at figure 29. If you look at federal outlays total, Medicare non-discretionary, defense discretionary, Social Security interests about seven percent, about seven percent of outlays at the federal level poured toward the states in federal matching payments. The next figure, number 30, will show you visually the range in federal Medicaid matching rates, the nominal rates at which states are matched, under the statutory formula and you'll see there's not any particular geographic logic to this because it's tied to per capita income. Not that there's any particular logic in tying it to per capita income, but it seemed a like a good idea in 1965 and here we still are.

The next slide will show you that, in terms of state spending, again on average you're going to get huge variations from state to state, but on average about 15 percent of the state general revenues go towards Medicaid. And the last chart will show you, we'll do this one step at a time,

as you're looking at it on the right currently about 43, 44 percent of all federal grants in aids to states, that's all the money the federal government sends to states whether it's in the form of highways, transportation grants, education grants, DOJ grants, 43, 44 percent are federal Medicaid matching dollars. And over time as you'll see between 1987 on the left and 1999 that percentage as the pie has grown, that percentage has increased as well and at least under current law you'd expect that trend to continue.

Now, I want to close my little presentation here by taking you to one more handout in your packet, which is one-page chart. It's labeled, "Intergovernmental Transfer in PIA June 14, 2000." And we've talked a lot about the FMAP or the federal matching rate as being the statutory formula. Now, the old-fashioned way to change the statutory formula is to go to Congress and say my state is not getting enough help from the federal government. I'd like raise the matching rate. Change the formula for my state.

And in the consolidated appropriations legislation that you all enacted in December in Section 706 of H.R. 5616, which was enacted by that legislation, Alaska duly had its matching rate raised. So it is possible to do it that way, but there's a new economy way of doing it now. And there are different ways of characterizing this. I'm going to use the congressional Budget Office way, which is there's an upper payment limit financing mechanism or UPL financing mechanism. And I'm going to use Pennsylvania as example because there was an audit review done of the Pennsylvania transaction that is available on the Web. It was done the Office of the Inspector General at the Department of Health & Human Services and I'd invite you to read the whole audit in full detail. I'm going to just sketch out the way this transaction worked.

This is one of two transactions that occurred in the year 2000 that Pennsylvania used and it had the effect of raising Pennsylvania's matching rate from 54 percent to 65 percent, okay, and here's how it works. So of course we need to borrow some money to start this transaction. So we're going to start up in the upper left-hand corner with the bank notes and step one is take \$695.6 million and borrow that from the bank and all these accounts are within the same bank and this transaction occurs all within the same day. There are 20 counties in Pennsylvania, all of whom run nursing homes. You can see them listed there and they borrowed this amount of money and then in the second step they transferred that amount of money to the Department of Public Welfare, transaction account.

Now what the Department of Public Welfare then did was from its general fund put in another \$1.5 million, see there on the right, step three, from the

DPW general fund. That's going to go into the transaction account and that will raise the amount of money there and then what the Department of Public Welfare will then do is combine those amounts and send them back to the county and that is the payment. That expenditure is what people variously categorize as a UPL expenditure, that is an expenditure that the Department of Public Welfare in Pennsylvania says is for nursing home care for the Medicaid patients in the 20 counties.

Now of course once that expenditure is made, the federal government federal government will put in its \$393.3 million, which is 54 percent. That's the nominal matching rate. You can see that in step five. That 393 million of course does not go into the 20 county accounts because all that money's been borrowed and it's just going back. Instead that \$393.3 million goes back to the DPW general fund. The counties then have the 695.6 million and they transfer it back to the bank returning the money that they borrowed earlier in the day and they take the \$1.5 million and put that into their own account for transaction purposes and those are the kinds of accounts that consultants like me just love.

Now, according to the Office of Inspector General, the \$393.3 million, none of that reached the participating nursing facilities and the Medicaid residents in the facilities reached no additional services. Pennsylvania retained the entire amount to use at it pleased. Again, this was just one of two transactions that year by Pennsylvania. The other one netted them 465 million according to the Inspector General. The total that year would have been \$858 million in unrestricted federal matching funds.

You could look at that in a number ways, that would be \$425 per nursing home resident per day. You could look at it in contrast to federal appropriations for various programs. It is more than entire amount that was spent that year on the ADAP drug assistance program, more than the entire amount that was spent that year on the MCH block grant for all states. The Congressional Budget Office in the budget and economic outlook that, you know, they present to the Congress each January has identified, in addition to the factors that Diane mentioned, prescription drug costs and increased enrollment, they identified these UPL mechanisms as cost drivers for federal Medicaid expenditures, and with that, my seven minutes are over. Thank you.

MR. HOWARD: Those of you who came in for Medicaid 101 have just had a taste of graduate level education and you better go back to the Inspector General's report to get a fuller explanation. I also ought to mention that the updated an not very different matching percentages for the current year and 2002 are in your materials on a separate sheet. Okay.

I think there's no truer statement about Medicaid than that it is largely shaped in state capitals around the country and one of those places is Providence, Rhode Island and the main shaper there is none other than our third presenter, Christie Ferguson. Christie is the commissioner of Rhode Island's Department of Human Services. And for many years before that, she served as counsel and deputy chief of staff to Rhode Island Senator John Chafee. Diane mentioned Christie's work on Medicaid and if you were around during the debate on the Clinton health plan, you'll remember that the John Chafee alternative bill that Christie put together had, what, 22 Republican co-sponsors in the Senate. What might have been. In any event, Christie has a unique combination of insight and experience with Medicaid at both the federal and state levels. And today she's going to share with us some of that insight, specifically about Rhode Island experience and we're very pleased to have you with us today.

MS. CHRISTINE FERFUSON, RHODE ISLAND DEPARTMENT OF HUMAN SERVICES: Thank you very much. Both Diane and Andy are hard acts to follow. They've always been hard acts to follow, but I've always followed them. I only have seven minutes and as you know there are only a few things that can be done in seven minutes and one of them is not necessarily explains what goes on in a state related to Medicaid, but let me take a crack at this from a more political and sort of opportunistic staff person approach.

If you're trying to carve a niche for yourself or your boss there is no better place to do it than Medicaid. The fact of the matter is that the range of people who are affected in a state by the Medicaid program is very broad. In our state almost 16 percent of the population receives some medical assistance from the Medicaid program. That's a very large percentage. It's going to vary from state to state, but the fact is that it's a very fruitful or rich place to mine if you're really trying to look at constituent groups and trying to help them. So, from a very practical matter, regardless of how complicated it is, regardless of it being the poor sister at the federal level in terms of attention to Medicare, it is at the state level an extraordinarily important program and it helps an awful lot of people.

And I'm just going to kind of walk through it more from that perspective than the perspective you've just heard from because my interest is getting you interested in this. So that as changes are made or as opportunities arise, you are in a position to take advantage of them and to maybe work with some of us on improving, expanding or reshaping the program. The first thing you need to know, and if you have gotten it from the slides, is

Medicaid is not Medicare for poor people. It is not Medicare for poor people nor is it commercial insurance for poor people.

The Medicaid program and opportunities are much broader in terms of the kinds of things that they cover and the kinds of things that states cover. So when you think about health insurance, you think about healthcare if you think automatically about the coverage that you have through FEHB or that people have through Medicare that is not the same program or the same kind of benefit structure as you will find in Medicaid. State budgets are driven by Medicaid, state budget costs are driven by Medicaid, in some cases more than education. Education and Medicaid are the two things that state budgets are driven by. At the same time, state budgets are supported by Medicaid. So, and it usually takes a governor and budget officer between two and three years to figure this out truly.

So as you have new governors coming in, as you have new people coming into your state government, they're not going to figure this out right away. You could give them a big hand by helping them figure it out faster. Cutting Medicaid is extremely difficult to do in state. Why? For the opposite side of the coin that Andy just described. If you cut a program in Medicaid because you need to balance your budget at the end of the year, if you cut a dollar out, you only get credit for 50 cents because it's 50/50. So you're causing a dollar's worth of pain, but you're only getting 50 cents worth of savings.

So that when the state budget officers and governors and cabinet members and legislatures are looking at places to go to cut funding to cover tax cuts or to do expansions in other areas, what they quickly find out is the amount of agony they go through to cut the program isn't worth the amount of savings that they get. It is there a real love/hate relationship therefore on the part of states, both on the legislative level and the cabinet executive level, there's a real love/hate relationship with Medicaid because it offers wonderful opportunities, but you can't really control it once it starts. Once you start a Medicaid program, you'll never go back and most states haven't.

An example of the kind of opportunity that it presents and why you can't compare it to a Medicare or a commercial or an employer based coverage is something like this. We, two years ago, we came up with the idea four years ago, it took us two years to get it through just the administrative process, we found that because we have aging housing stock in Rhode Island, we had a tremendous amount of lead poisoning. And lead poisoning has a tremendous impact on education costs as well as just basic healthcare costs.

So we decided, and we did some investigation as to what the major causes of lead poisoning were, and it so happened because of our aging housing stock, about 80 percent of lead poisoning was a result of windows opening and closing. So you get wood windows that open and close and the dust comes out. So in effect what we did, and we're now doing, is we're paying for the replacement of windows through Medicaid, as durable medical equipment in effect and we have a revolving fund so we place a lean on the apartment building so that when it's sold, we'll get paid back. But in effect, we're paying for replacement windows upfront, we're providing a loan to landlords who otherwise are not going to do it and we are working on preventing lead poisoning.

That's the kind of thing you're not going to find a commercial health insurance plan doing nor are you going to find the Medicare plan doing because it is a little bit to far out of the box for traditional health insurance, but the impact on the overall state budget and the overall health of kids is a no brainer. So, those are the kinds of things that you'll come up with. It's a poor sister, Medicaid is a poor sister at federal levels because you've got so many different programs in every state, but it's 800-pound gorilla in states. It is the most loved and most hated program and it's an opportunity, it provides an opportunity if you look at it from a positive perspective or it has an impact on, and sometimes negative, the entire healthcare industry in your state, again, a huge percentage of the population and your state government.

We have seven state agencies, cabinet-level agencies that have Medicaid designated responsibility or delegated responsibility for services. We have seen dramatic changes in the last few years around the organization and management of Medicaid. Again, every state is different, but there have been some really wonderful improvements from my perspective. In our state managed care was an unqualified success. Now granted we pay our insurance carriers close to what the going rate is. If you try to pay them at 50 percent less than what they're getting from everybody else, they're going to back out. Not hard to understand why that might be.

We have 6.9 percent of the population uninsured. We're the best in the country from that perspective. We saw, and you'll see in your packet, I gave some of the health results, the health outcomes. One of the most dramatic was a period of time during which women waited to have second children. It started out as a huge gap between those who got their insurance from their employer and those who go their insurance from Medicaid and within a year-and-a half, the gap was closed to almost no difference. So that as women got more information and had consistent physician/patient relationship what we found was that they responded in the

same way than upper middle-class family would respond to that information and that I think is an important finding.

Our satisfaction rate is 98 percent, high or very high and it provided us with a platform on which to expand so we do cover parents up to 185 percent of poverty and we provide at total state cost. So we pay 100 percent of the premium health insurance to childcare providers who take a certain percentage of subsidized kids. So the relationship between Medicaid and other social programs that states do is an important opportunity and very critical. In terms of other kinds of trends that we're seeing, children and adults with disabilities as a group, our enrollment is increasing at higher than the national average, but the national average is also going up pretty substantially. And we're projecting a 14 percent increase in the cost for those folks and children with special healthcare needs, the same thing is happening and we're projecting a 13 percent increase in cost.

If you look at purely from a Medicaid perspective that's a lot, but it's impact on education again is a pretty critical thing to look at. The relationship between kids and young adults with disabilities and the educational system is really an important thing if you're looking at the outcome of the family. The FMAP changes always lag behind what the actual experience in the state is so we've had our FMAP reduced, the federal payment to us reduced and it's out of cycle with the economy. So when it goes up it's actually during good times. When it goes down, it's during bad times it's a very bad cycle to be on. It should be the opposite. I don't know how that's ever going to be solved. It's always been a problem.

And my two last points really relate to another area that people don't understand very well in states as well as at the federal level and that is people who are duly eligible for Medicare and Medicaid, which you've heard a little bit about from Diane and Andy. Fourteen percent of the Medicare caseload is duly eligible, eligible for both Medicare and Medicaid. Thirty-one percent of all Medicare expenditures are for that population. At the state level, 18 percent of the total Medicaid population, this is in our state, is eligible for Medicaid but it represents 55 percent of the cost of Medicaid in our state.

And we're experiencing double-digit growth among that population in home healthcare because of the changes that were made in Medicare as well as the Part B premium increases. Every time that happens, it has an impact on the Medicaid budget. And at the same time we're seeing a reduction in our utilization of nursing homes as a result of it, but that that change is a hard one to get through. Medicare and Medicaid interact in an extremely

important way at the state level. There is a lot of cost shifting that goes back and forth.

We are one of the only states that has Medicare data for the last five or six years that we have actually matched with our Medicaid data. It is so clear on the acute care side where we could do a better job of managing jointly Medicare and Medicaid recipients. It's something that the federal bureaucracy is very reluctant to look at, but it's something that I think holds a lot of promise for both quality of services and quality of care as well as expenditures. So, I would leave you with this is really something, as a program, that offers you opportunities that you will not find in other areas as a staff person and it's worth getting to understand it well enough to really try to put your imprint on it. Thank you.

MR. HOWARD: Thank you, thank you very much, Christie. Those are good messages. Now, we get to some of these questions that might have been engendered by something you heard. Those of you have to leave before the Q&A session is over, let me ask you boringly repeating myself, if you would fill out the blue evaluation form you'll find in your kits so that we can sharpen and improve these programs for your use.

As to the questions, there are green cards if you want to write a question down and hold it up, one of our staff folks will pluck it from your fingers. And as some of you have discovered and are using there are floor mikes that we encourage you to come to in order to get your question asked. And if you'll bear with me, I want to do a card question first because Cindy O'Flaherty from Jerry Costello's office has asked, what are the specific guidelines to qualify for Medicaid in the state of Illinois, income, home ownership, et cetera, et cetera?

And the intrepid staff of the Kaiser Commission is prepared to respond to Cindy and has material in the back if you will stop and talk to Rocashe Sing (sp) that material is available for you. I'm impressed so let's go to the front microphone for the first question. You want to identify yourself please and try to keep your questions as short as you can so we can get as many of the simple questions and I encourage you to be as basic in your questions as you possibly want to be. You cannot embarrass yourself in this situation. Go ahead.

MR. CRAIG PALMER, ADA NEWS: Question for Andy Schneider. Thank you for the OIG's chart. Could you tell us just a little bit more about the unrestrictedness of this use? Is it unrestricted use within Medicaid, unrestricted use within the state's general fund, unrestricted use within the

state, could it be spent for windows, could it be spent to repair the Pennsylvania Turnpike?

MR. SCHNEIDER: Yes.

MS. FERGUSON: Yes.

MR. PALMER: And who's going to know how the money's spent?

MR. SCHNEIDER: Unrestricted and again you should go and you should look at the entire audit review. There's several appendices there in which the Inspector General's staff worked with the state to try identify where in fact the money went.

MR. HOWARD: And speaking as a native of Beaver County Pennsylvania, I think that's perfectly fine. I'll alternate with a card, if I can. We're especially interested in Medicaid coverage of pregnant women, which states offer presumptive eligibility and are there good examples of outreach to pregnant women?

MS. ROWLAND: About 28 states now offer coverage and we can get you those specifics. We're in the process of updating a report that should come out within the month that will have the latest statistics on which states do presumptive eligibility so we'll get that information to you.

MR. HOWARD: Okay. Yes, the question at the rear mike, please.

MR. SAMUAL GOLDREICH, CONGRESSIONAL QUARTERLY: This is to Andy and Christine in particular. I'm wondering what impact you think the national governor's views on Medicaid might hold for the issues you've talked about and secondly, the ideas of pulling HCFA apart that Tommy Thompson's been talking about?

MR. HOWARD: And somebody might want to describe what the governor's views are. I mean it's really hard to discern something from the statement that I saw.

MS. FERGUSON: I think we have somebody from the NGA here who could probably do it, but I think the bottom line is more flexibility and opportunity to provide services without having to go through some of the hoops that you have to go through. I'll give you an example. In Rhode Island because we expanded eligibility under 1931 Medicaid for adults, which is basic Medicaid, we couldn't charge a co-pay and we decided to do it quickly as opposed to waiting for a waiver. So after the July 1st letter came out from the previous

administration that allowed us to use CHIP money for adults, we asked a waiver to move people into CHIP and we are now in a situation where we are not allowed to charge any kind of a co-pay or premium to those adults, but we are required to for their children.

And it's taken us nine months and a new administration probably before we'll be able to have parity between the two. So it's things like that that just don't make a whole lot of commonsense. From a long-term perspective of the history of the Medicaid program, you can understand why the policies are the way they are, but from a commonsense, real-time perspective it's very difficult to understand. Those are the kinds of things I think that the governor's are looking at.

MR. HOWARD: Andy.

MR. SCHNEIDER: I think all I'd say is, you know that's an empirical question you want to watch as things play out. On the upper payment limit issue, you might want to see how the administration's proposal in the "Blueprint for a New Beginning" on page 1114. They suggest here that they want to prohibit new hospital loophole plans approved after December 31st, 2000 from receiving the higher upper payment limit and that I think will be a good test of the conversation between the states and the federal government.

MR. HOWARD: And there's actually a related question on the card. What do you think of President Bush's plan to give states the flexibility to reduce the benefit packages for optionally eligible Medicaid recipients? I frankly wasn't aware that there was a President Bush proposal as opposed to the NGA. Is that correct?

MS. FERGUSON: I just heard about it today. Andy, do you know about it?

MR. SCHNEIDER: I don't.

MS. FERGUSON: None of us have read it, but what I was that there's a proposal to allow the states to take different populations and tailor the benefit packages. There are upsides and downsides to that. I think you have to look at it from your individual organization or constituency perspective. I think that the big fear is that some folks that have benefits now that are non-traditional medical benefits will lose them. I can only tell you from a perspective of actually looking at utilization rates and cost per benefit, generally the things that people think of as extraneous really don't cost that much overall. They cost less than a dollar per member per month, but the ability of the state to make those decisions I think is something that

they're pushing for very hard and we have somebody from the NGA here. Right?

MR. MATT SALO: Yeah, this is Matt Salo with the National Governor's Association. As you know, we passed a policy at our winter meeting about a week-and-a-half ago calling for a number of changes in Medicaid sort of two tracks, one being administrative and regulatory sort improving the way HCFA works and improving the state/federal relationship. And doing away with things like, you know Rhode Island's two-year journey to get a waiver passed, but also we were calling for a framework of sort of restructuring to the Medicaid program itself recognizing that it sort of serves two purposes, one as sort of a safety net for vulnerable populations and the other sort of as the program has progressed beyond 1965 as sort of more of a mainstream insurance program. And you know the ability to sort of address the all-or-nothing problem with Medicaid coverage, you know to be able to allow states to both, you know stabilize their out of control budgets, but also giving them the tools to expand coverage to the uninsured. Our policy's up on our Web site. I don't want to speak for any congressional interest in it. Perhaps some people here could talk to that, but I'm more than happy to talk about what's in our policy.

MR. HOWARD: Thank you.

MR. SALOW: Thanks.

MR. HOWARD: Yes, at our first microphone.

MS. LAURA MECKLER, ASSOCIATED PRESS: Hi, I'm Laura Meckler from the Associated Press. My question, I have a few questions related to this upper payment limit loophole situation. Number one, how many states have been doing this? Number two, I understand that Congress has phased this out or has got rid of it, but phasing it out it was described to me as, so that the states that got in at the last minute have a chance to take advantage of it before they get rid of, I wonder if that's true? Three, how much would it save if you did and the loophole today? And lastly, I want to make sure I understand this chart. My reading of this is that what Pennsylvania did was essentially was putting in \$1.5 million of its own money, but getting matched for \$695 million, is that right? The match was based on \$695 million, but they were really only spending 1.5 million of their own money.

MR. SCHNEIDER: I'm sorry I didn't explain that clearly. Let's try it again.

MS. MECKLER: I mean I understand the basic idea that they're pretending like they're spending money to get it back.

MR. SCHNEIDER: The money was borrowed by the counties, the 695 million was borrowed by the counties.

MS. MECKLER: Right.

MR. SCHNEIDER: It was transferred to the state account.

MS. MECKLER: Right.

MR. SCHNEIDER: And that was the basis for the state expenditure. Now that's what you apply the nominal 54 percent statutory federal matching rate to.

MS. MECKLER: Right.

MR. SCHNEIDER: And that gives you about 393 million, okay? The \$393 million federal dollars in Medicaid matching payments went to the DPW account. The 695 plus change, right, went back to the counties who then took a million-and-a-half off the top, put it in their own fund and gave the rest back to the bank.

MS. MECKLER: So the real-live state money that the states were giving the counties was not 1.5 million?

MR. SCHNEIDER: It was about 46 percent of that because they got matched on the 1.5 million as well.

MS. MECKLER: I mean the way it's supposed to work, and I'll shut up then and let someone else ask a question, the way it's supposed to work - -

MR. SCHNEIDER: The way it's supposed to work.

MS. MECKLER: The way it's supposed to work is that federal government actually matches the actual state spending. So the state was pretending to spend \$695 million that it wasn't really spending. I mean is that what it is?

MR. SCHNEIDER: Well that'd be one way to look at it.

MS. MECKLER: Okay. Accurately way to look at it?

MR. SCHNEIDER: Well, you'd have to ask the state what its perspective was.

MS. MECKLER: Okay.

MR. SCHNEIDER: You know a part of the problem with this program, as Christie I'm sure will tell you is, looking at it from the state direction, the program looks a little different than from the federal direction. And you know there's been a robust, entertaining and ongoing dialogue in the friction between those two perspectives. But you know if you look at the OIG audit that is the, and since we're talking to congressional staff here, I thought the federal perspective would be of interest and the OIG audit describes in withering detail the federal perspective on this.

MR. HOWARD: Andy, you want to take a quick crack at other parts of Laura's question about the number of states and whether or not there's been a fix?

MR. SCHNEIDER: Well, it's hard to get information on this. I would encourage you to ask the Secretary and ask HCFA to get the correct information. Those are the right questions. My count was 25 states. That could be wrong. There were in fact regulations issued by the previous administration, which would phase this out by 2008, those regulations are currently suspended by a January 20th presidential chief-of-staff directive. I don't know what the status of that discussion is. The OIG audit review does explore some of the savings estimates in connection with the Pennsylvania transactions. I've been trying to locate the Congressional Budget Office estimates for the action that the Congress took last year in directing the administration, the previous administration, to issue regulations to address this. Those estimates are not available for the bill that was enacted in December and so that's all the information I have for you.

MR. HOWARD: Thank you. Yes sir.

MR. SAUL FRIEDMAN (ph), NEWSDAY: Yes, I'm Saul Friedman with Newsday. I'd like to shift the focus a bit and ask whether there is any evidence that the growth in long-term care spending of Medicaid has been generated by Medicaid planning which is a target in my state and I'm just wondering whether Medicaid planning and fund transfers and deliberate impoverishment has generated the growth in Medicaid spending for long-term care and if so, to what extent?

MS. FERGUSON: There have been numerous, numerous reports and studies done on this issue. I don't think there's any question that there's a whole industry around how you plan your estate so that you're not subject to spending your money on long-term care facilities. But over the course of the last 15 years, I think that the Congress has sequentially tried to make

that more and more difficult. It still happens and I don't think you're ever going to put a total and complete end to it. There's always going to be an expenditure for that that.

MR. FRIEDMAN: Yeah, but to what extent is it a problem?

MS. FERGUSON: I don't know what the latest – do you know what the latest numbers are?

MS. ROWLAND: It's been hard to document to what extent it's been a problem. For the most part, none of the studies have shown it as a huge problem. And if you look at the number of people who are being covered in nursing homes on Medicaid, they are pretty stable. What has gone up in terms of the cost is more the expenditure per person, which is more reflective of the increased cost of nursing home care than it is of a lot of additional people being made eligible for coverage.

However, I'd also point out that when you look at who pays in a nursing home, we're not seeing massive transfers because we still have a lot of individuals in nursing homes who are paying the full freight for their care. We have a modest increase in some private long-term care insurance and Medicaid is still providing the bulk of care, but it's mostly for people who are at the margin. Many of the people who come into nursing homes on Medicaid have already qualified for Medicaid in the community on the basis of their acute and long-term expenditures through spend down and so they're not really coming in exclusively for the nursing home benefit. So I think it's always talked about. I think there's a big industry out there that does a lot of advertising on it, but I think from most of the evidence we've seen, the use of it is still pretty much at the margin and it's often for people barely above the Medicaid level, not for people who have millions of dollars because they wouldn't exactly want to be a Medicaid nursing home patient.

MR. HOWARD: Do people understand the question that's being address, this business of Medicaid planning? Okay good. Let me do one card question. There are two coverage programs for children, CHIP and Medicaid. How do they differ and is one better than the other?

MS. ROWLAND: I think that depends on what state you're in and in Rhode Island our CHIP program and our Medicaid are the same. We're one of the states that united them. The big difference is the difference in the entitlement nature. CHIP is not an entitlement, Medicaid is. The matching rate is much higher for example in our state. It's a 67 percent matching rate for CHIP versus 51 percent matching rate for Medicaid. You have the ability to tailor benefits more narrowly under CHIP than Medicaid. Are there

any other obvious things? Oh, you're allowed to charge cost sharing to CHIP recipients that you aren't allow to charge for Medicaid recipients. So it's those kinds of issues, but you really want to look state by state, at your own state, to see the differences in the program and which you individually think are better.

And if you look at it from Andy's federal side of it, the difference in the two programs, is that the Medicaid program is an entitlement program and there's no cap on the amount of funding that a state can draw down. So all services to eligible individuals continue to be matched at the rates that Andy talked about. And so the more people you cover, you don't have to worry about running out of funds at the end of the year. CHIP, on the other hand, has a fixed allocation per state that can be rolled over and used, but the matching under the CHIP program is available up to the ceiling on that allotment so that it's a capped program with more flexibility for somewhat higher income children than Medicaid is an open-ended entitlement program for children at lower eligibility levels.

MS. FERGUSON: And if you look at it from a very traditional state perspective, what that does is give you absolute target. You know exactly how much you're going to spend. You don't have to worry about if your estimates were off by two percent, your expenditure at the end of the year is off by three or \$4 million and you have to cut some other program to balance your budget by the end of the year. So from a budgetary perspective in a lot of ways, CHIP is more predictable for a state and you don't have the entitlement perspective. From a beneficiaries perspective, the fact that there's not an entitlement is a big problem.

MR. HOWARD: And there is a question card here that notes that North Carolina has frozen enrollment in its CHIP program and I know some of the counties in Florida have done the same over the years. We, by the way, are planning to do a program on the ABCs of kids' coverage encompassing both CHIP and Medicaid some time later this spring. So we expect to be able to address a lot more of those questions in more detail at that time. Yes.

MS. DIANE DUST, PRUDENTIAL SECURITIES RESEARCH: Hi. My name is Diane Dust and with Prudential Securities Research. And I noticed in the packet you included a page on 1115 waivers. I was wondering some of the states, Vermont, Maine, New Hampshire, I think Rhode Island might be looking into this, have amended 1115 or are attempting to amend 1115 to expand drug coverage so that people that are a little bit beyond the Medicaid population can get drugs at the Medicaid rate. Because of the rules surrounding 1115 that is described here to be a pilot demonstration project, a substantially new idea. Is there a point as far as HCFA's concerned there

are enough of that kind of 1115 waiver out there so that more states can't come in with the same idea? Specifically, I'm thinking about this drug program and if it's reached saturation level as far as 1115 waivers go or all the states could get in on something like that if they chose to?

MS. ROWLAND: Well, originally 1115 waivers were intended to test new ideas expansions and were used almost exclusively for a demonstration program that could then be evaluated. And in the last eight years, we've seen a real shift in the way in which the waiver authority has been used. It's not as flexible as Christie and the states would like it, but it's now being used more to expand and modify provisions of federal law as long as it stays budget neutral and doesn't cost more than it would have otherwise cost and that's part of what this whole debate now is about in terms of asking for more flexibility and a different process by which states could make the kind of changes that they've been doing through the 1115 process.

So I don't think it's left anymore that only demonstration of something would happen. It's now a vehicle for broadening the ability to provide coverage under the Medicaid statute, but there's other ways that are being looked at as well and the governor's proposal I think speaks to that to try and let states have even greater flexibility over those modifications.

MS. DUST: If I could just follow-up on that, the, as you probably know in Vermont, the pharmaceutical companies are challenging this waiver that is supposed to be into effect right now, saying that what they've done in Vermont is part of the objective of Medicaid. Is there credence to that as far as you're concerned and what you know about Medicaid?

MR. SCHNEIDER: Let's just take it one step back. Title XIX of the Social Security Act authorizes federal funds to be made available on open-end and matching basis to states that make appropriate expenditures and have what's called approved state Medicaid plan. There are lots of requirements in XIX, too many for some people's tastes, but those requirements attach to the expenditure of federal funds. There's another section of the Social Security Act, Section 1115, that grant discretion to the secretary to waive those requirements but still allow states to receive federal matching funds for expenditures they've made.

For example the state of Oregon did not like the Medicaid benefit package and they got a waiver, which is still in effect, allowing them to receive federal Medicaid matching funds for a different benefit package. The federal matching funds were also made available for populations in Oregon that are not generally matchable in other states. So you could go through each state, whether it's Rhode Island or (inaudible), and the basic understanding

is Congress has delegated to the secretary the authority to define the terms under which states can draw down federal matching dollars on an open-ended basis. Believe it or not we're do your answer.

So what do the federal courts have to say about all this? They're looking at a statute that Congress has enacted under the Commerce Clause authority and under what terms will federal funds be made available to the states. Congress has delegated substantial discretion by statute to the secretary to substitute his or her own judgment for Congress's in terms when states can get federal money for what. What's the role of the federal courts at that point? There's not much case law on it. My own reading of the case law is the federal courts are very differential. It's very hard to get a federal court to overturn the secretary's judgment in terms of how he or she uses his or her discretion to approve the use of federal funds. It's not impossible. It's happened, but it's not a common occurrence.

MR. HOWARD: We do a quick card question. How is Medicaid's coverage of the disabled different from Medicare's coverage of the disabled? Diane you mentioned that there was a relationship between the two anyway.

MS. ROWLAND: Well there's two issues here. It's who's covered as disabled and then what the benefit package is. And for coverage under Medicare as a disabled individual you have to qualify for disability under the Social Security Act and go through a waiting period for disability benefits followed by a two-year waiting period for Medicare coverage. So there are some individuals who are going to become Medicare disability beneficiaries, but they're in a waiting period and if they're low-income Medicaid will cover them during the waiting period.

In addition, Medicaid covers other individuals who do not have the attachment to Social Security to be able to qualify for benefits under the disability insurance program who are low income and on Supplement Security Income cash assistance and they use the same criteria for disability, but they are lower income and they are eligible for Medicaid and there are rules again that vary while there's a basic income standard set by the SSI program that all states pretty much agree to, some states have other provisions for eligibility levels for the disabled. The biggest difference between the two programs is that, even if you're Medicare, you're mostly getting the basic acute care services that Medicare covers if you also have Medicaid coverage, you then get the long-term care, the rehabilitation services, some of the mental health benefits that are not available through the traditional Medicare program.

MS. FERGUSON: And in many cases you'll get the co-payments that you have to pay under Medicare covered by Medicaid.

MR. HOWARD: Yes.

MS. ANN MARIE MURPHY, SENATOR DURBIN'S OFFICE: This question is mainly for Andy. As the states obviously have experienced large increases in their prescription drug costs in Illinois, 22 percent last year, expected 20 percent increase this year, have you seen looking at the different state strategies to get their arms around these costs, effective strategies that curtail costs without curtailing needed benefits and are there any other tools that the federal government could give the states that would appropriately deal with costs without undermining necessary benefits?

MR. SCHNEIDER: Well, that's an excellent question. I honestly have not followed state prescription drug policy initiatives that closely. I know there's some research underway on that. I'm really not competent to speak to it. The one thing I would note is, we haven't talked about this, but at the federal level as a result of some changes enacted in 1990, there is a rebate mechanism under which both the states and the federal government receive rebates from manufacturers who agree to participate in the Medicaid program.

Condition of making federal matching dollars available for prescription drugs under Medicaid is that the manufacturers participate in this rebate program. And there was in fact some research that Kaiser recently commissioned on the effectiveness of that rebate program. I mean in the first place seems to me to look would be whether that could be improved upon because you're talking about a national leverage with the federal government and all the states together purchasing prescription drugs. I would think that gives you a little more credibility in the marketplace and take another look at that mechanism.

MS. FERGUSON: I can tell you – oh go ahead, Diane.

MS. ROWLAND: I was going to say we can also make available to you a survey that we've done of I think 44 states responded to it on what practices they have in place, formularies and other things to try and control and look at managing their prescription drug benefit.

MS. FERGUSON: The increase that we're experiencing as a result of both utilization and price of drugs is after the rebate. So when you're talking about 17 percent, you're talking about that is the rate of growth even after you've used a rebate. And a lot of it has to do with new technologies

available and the fact that you can't really use a formulary in order to take advantage of the rebate because of the way that the program was structured or the wall was structured in '90.

States are having a very difficult time dealing with this on an individual basis. There's been some attempt to do some regional collaborative. The difficulty is because both under Medicaid and Medicare you are dispensing drugs at a pharmacy it's very difficult to take advantage of the bulk purchasing or volume purchasing that you're doing as an individual state or a region. I personally think that we're going to find that it's not something that can be solved on a state-by-state basis. It's something that has to be done on a national basis if it's going to be done.

And having been through now I think when I was here, I was here for almost 15 years, and I think we went through three prescription drug debates and the only thing that ever happened was the Medicaid rebate program. It's an extremely difficult issue.

MR. HOWARD: Let me do one from a card. How do we encourage physicians to see Medicaid patients given typically low reimbursement rates to physicians? First I guess I would say is that right, are the reimbursement rates typically low?

MS. FERGUSON: Yes, the reimbursement rates are abysmal, but I would say that that's where managed care in our state proved to be an enormous boon because one of things that we did was to require that any physician who took basic (inaudible) sponsored coverage had to also take, if we bought insurance coverage from our major health plans, United, Blue Cross, at that time Harvard Pilgrim and Neighborhood Health Plan, we required that they paid at comparable levels and that every physician was required to open up to our beneficiaries. So we saw a two-thirds, almost three-quarter reduction in use of emergency rooms in our state by about 80,000, which is a huge number for a population of a million and a requisite increase in the use of primary care physicians.

The difficult is that that capacity of primary care in the state to absorb all of those people was not high. So one of the things that we're seeing is some strain on the primary care side. On the non-families and children side, on the elderly and folks with disabilities side in terms of basic preventive non-specialty service, dental services, the payment levels are not adequate to have offices open up on a broad basis. And again for Medicaid in terms of a driving expenditure for state budgets, you have three ways of controlling expenditures.

One is you can control who's eligible, that's eligibility. The other is you can control the scope of benefits, what the benefit package is and the third is you can control what you pay for those services and you will find that most states will control their expenditures not by either of the prior two because they like to be able to talk about how broad their eligibility is, but more with regard to reimbursement for services. And unfortunately the institutional providers generally get the bulk of reimbursement increases because the physicians are not organized and don't approach the issue in a way that can get people's attention.

So I think you'll find that that's true in most states. It's something I don't think states are particularly happy about, but from the perspective of overall driving expenditures and having to be able to balance a budget at the end of the year, you don't see a lot of increases. Managed care has been led to a tremendous improvement in that arena in many states that have gone the managed care route.

MS. ROWLAND: Although one of the more recent stories you're getting from some of the states is that under managed care, many of the managed care plans are squeezing back on what they're paying to providers there. So that in some states managed care came in as a solution to the low payment rates and is now it's in fact squeezing back further and so I think payment rates remain a huge problem within the program.

MS. FERGUSON: It's very difficult you can put clauses in when you negotiate those contracts. We just did. We said you have pay 95 percent of the Medicare rate and we went back and forth in negotiations. You have to pay premiums that support that rate of reimbursement and one of the difficulties is that this program traditionally has not paid providers at a high level. And so when you move over into managed care, if your goal was to save money, you're not really saving money.

That's really not the point. The point is more an improvement in quality and insuring that what you get in return for what you spend is a better value. And that's one of the problems when you get a third party involved in paying for provider coverage of services is that that third party has to figure out how much of its resources it's going to spend on those services and what value they place on those services.

MR. HOWARD: Okay we have about five minutes left. Go ahead, Bob.

MR. BOB GRISS, CENTER ON DISABILITY AND HEALTH: Bob Griss with the Center on Disability and Health. Most of this discussion has been focusing on Medicaid as a silo, a separate program with a funding source by itself, a

unlimited set of objectives and some limited options that the state has for containing costs. And I see that many states are using Medicaid expansions and CHIP expansions to deal with the uninsured. Rhode Island is a wonderful example of a state that's doing that.

I'm wondering if another funding stream that can help finance the Medicaid CHIP program wouldn't be buy-ins from non-Medicaid eligible people, but other groups in the community who also need effective, affordable healthcare? In other words, if states used their Medicaid and CHIP programs to market a service that can be provided more efficiently than the commercial insurance world, would that not be another way of financing the types of services, in terms of promoting people's health needs rather than just looking at it a separate silo with it's own defined population since we're talking about really a generic need in the community?

MS. FERGUSON: That was a proposal that we actually went through in a health reform debate in Rhode Island was to allow people, allow small businesses as well as individuals to purchase at the premium rate. The difficulty that you run into is depending on what your marketplace looks like insurers are not particularly enthusiastic about having people get the advantage of a negotiated rate in bulk when they have been able to charge based on smaller groups and risk basis and you have a tremendous battle with the insurance industry around those issues.

I would say to you that I think over time that's likely to happen as rates again, we're now in an underwriting cycle when rates are increasing at very, very high levels. And I think you're probably see in some parts of the country, a move toward that kind of a mechanism. In other parts of the country you'll see a move away that kind of a mechanism and into other kinds of buying groups. But it's heavily complicated by insurance regulation and insurance rules and what carriers have to and don't have to do currently.

MR. HOWARD: I've actually got a follow-up question here that fits very nicely, and let me remind you to fill out your evaluation forms as you leave. Many states, according to this questioner, including Rhode Island have been very aggressive in expanding Medicaid to new low-income populations, but two problems have arisen, one a crowding out of employer sponsored insurance for low-income employees and second explosive growth in spending that has overwhelmed state budgets. Is it possible to provide comprehensive healthcare benefits to the needy, low-income Americans without these undesirable effects?

MS. FERGUSON: Yes it is. Part of the problem is being able to implement. It's the clash between the 1960s and forward growth of Medicaid policy, which limits your ability as a state to put any kind of restriction on coverage when you bring people in. The 1115 waivers made it possible to do some of that, but I think that that interaction at the margins, and when you talk about that you're talking about margins of people who are at 133 to 150 percent of poverty. For a family of three, that's roughly \$20,000 a year, which is not a lot of money if you're talking about taking 100 or \$150 a month out in premium share. Even three percent of your income is a high amount at that level depending on where you're living.

And so I think that the rub that we're getting into is when you look at the population who where you do have some crowding out, which is lower-end, lower-income individuals who may not be able to afford the premium at an employer. Is that crowding out or is that an issue of income supplementation? And my personal perspective is you should make it on the basis of income some contribution sliding scale and that would simplify the whole process. Let people continue to stay in their employer-based coverage and supplement those premium for very low-income families and I think that that solves a lot of the crowding out issue. Unfortunately, that's not the way any of our programs are set up and the methodology to get there is not easy because of the complications of the history of the Medicaid program.

MR. HOWARD: Let me just read - -

MS. ROWLAND: I would also challenge the explosive growth term because I think that you have to be very careful when you expand enrollment and you enroll more people, you do expect there to be a cost attached to new enrollees, but it's not explosive when you're looking at the cost increases related to mostly expanding coverage to children, who as I showed you, were among the least expensive of the Medicaid population.

In addition to that, much of the growth that we've seen in the past when Medicaid was quote, "explosive" came not from coverage of the populations, but from some of the more creative financing mechanisms that Andy talked about that led to the real double-digit growth during the early '90s. And the other point that I think you ought to bear in mind is the one that Christie made, you can't guarantee access unless you're willing to pay providers to provide those services. So that when we see healthcare costs generally going up, we can't expect the Medicaid program to stay at a constant level while the rest of our healthcare spending has gone up.

So to some extent, Medicaid is also influenced by being in the same market for healthcare services as Medicare and private insurance. So when drugs and other things are going up in the private sector, they're going to be also influencing the size and scope of Medicaid budgets and it's the complexity of what this program covers and who it covers that contributes different growth rates in different parts of the population.

MS. FERGUSON: And you have to put this into perspective, when the explosion issue isn't so much the number of people that got covered. It's the lack of ability to estimate effectively within the budget year of how many you thought were going to be covered. That's the reality of it. I think that people in general thought there would be a substantial increase in eligibility but that it would happen over a period of years. If we are off by one percent, if our estimates are off by one percent, and those of you who are in politics, know that the three to five percent is okay with polling, one percent error in Medicaid budget and you're on the front page of the paper because you have to balance the budget at the end of the year.

And if your one percent error is in April and the end of the year is in July, you are you know what. So I think that in the context of the sense that there's explosive growth, you have to put into perspective in terms of what the media is reporting and why it's reporting it in that particular way at that particular time again because you have huge growth in the caseloads, most of which was expected. So you have growth in families and kids that's not where the big expenditure growth is really. The big expenditure growth in all states has been drug utilization and expenditure, adults with disabilities and children and with disabilities who come at great amounts.

But because the media is more familiar with the expansion in kids and families, they tend to report the growth in expenditures around kids and families and they don't look at it from the perspective of where the real growth is occurring, which is in that core set, which would have happened whether you had the expansion in kids or not. And to try to explain that to a reporter, no offense to the ones that really understand the Medicaid program, if you've got a reporter who's never dealt with the Medicaid program before or very rarely, they're not going to take the time, because they've got a 4 o'clock deadline, they're not going to take the time to really understand what you're talking about and it makes a great headline.

So you just have to be careful about really understanding where the growth is occurring and looking at this from a perspective of different population groups and again adults with disabilities, the elderly and kids with disabilities, because of the drug utilization among that population, is really growing at a much faster clip than kids and families.

MR. HOWARD: Well, that's a pretty good place for us to suspend operations. I apologize to everybody whose green card question we didn't get to. I'd like to say that everyone who turns in an evaluation form at the back of the room will be given a 1,000 gift certificate for Tiffany's. I'd like to say that, but that would be a lie. Nonetheless, please fill them out.

Thanks again to the Kaiser Family Foundation for its support, for the staffs of Kaiser and the Alliance and our wonderful panelists for this program.

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