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Briefing on State Medicaid Programs, the Recession and Health Reform
Kaiser Family Foundation
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DIANE ROWLAND: Good morning and welcome to this Briefing on State Medicaid Programs, the Recession and Health Reform. We appreciate all of you weathering the rain and the storm to be here this morning. We had hoped for a sunny day but perhaps the results we're going to talk about are more fitting to talk about on a gloomier rainy day.

I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation and the Executive Director of the Kaiser Commission on Medicaid and the Uninsured. We're very pleased today for, once more after 10 years, we've continued to provide a briefing to show you the results of our annual survey of Medicaid and state budgets and really to discuss the implications of today's budget situation and the Medicaid policy choices facing the states for the implementation of health care reform.

The findings depict the current situation. They also show some of the Medicaid directors' expectations for the coming year and the actions taken and planned in the states. We're very pleased that each year when we do this we have full

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participation from all 50 states and the District of Columbia. We want to really thank all the Medicaid directors for their time and their energy that they put in to doing this survey and for the survey team that manages to get all 50 states and the District on the radar screen each year.

This survey also serves, we think, as a really good baseline to assess the foundation now on which the coverage of the low income population under health reform will be extended through Medicaid. So we expect that we'll begin this year by looking at where the states are, what their coverage policies are, and how these may change between now and 2014.

Our budget survey is complimented today by another report in your packet that's a study of Medicaid enrollment that documents the enrollment growth experienced by states from the recession. We take a snapshot in December of each year and from December of '07 to December of '09, the heart of the recession, a six million increase in the number of people enrolled in the Medicaid program. So as we talk through some of the findings today, you'll clearly see the impact of the

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recession and enrollment growth on the choices and challenges that the states have faced.

In addition, as the states struggle with the recession, there are cutbacks in personnel. There are changes going on throughout their budgets. We wanted to look at some of the implications of these changes for the future implementation of health care reform.

So we're presenting a third report this morning that does a quick snapshot case study of some of the struggles and issues regarding state capacity that we're very pleased to add to today's agenda.

This session is really possible through the efforts of many but we want to particularly thank our longstanding research team and the authors of our 50-state budget survey, Vern Smith, Kathleen Gifford, and Eileen Ellis of Health Management Associates and Robin Rudowitz and Laura Snyder of the Kaiser Commission on Medicaid and the Uninsured staff here at the foundation together of course with all of the Medicaid directors who have made this report possible.

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We especially want to thank Carol Steckel, the President of the National Association of Medicaid Directors and the Commissioner of the Alabama Medicaid Program who is here with us today and will provide some direct, on the ground experience as a Medicaid director and as the coordinator of the Executive Committee of the State Medicaid Directors.

Finally, a new participant in this briefing, Elizabeth Kellar, the President and Chief Executive Officer of the Center for State and Local Government Excellence, for their case studies on state workforce and capacity and we thank her and her colleagues as well.

So we're going to begin today by really providing you with the context for which these budget survey numbers will take hold. So I'm going to turn first to Robin Rudowitz to set the stage and then for Vern to present some of the findings from our 50-state survey.

We're going to follow that up by asking Elizabeth Kellar to present some of the findings from their look at the workforce issues and then finally to do the wrap up and provide the perspective from Medicaid directors on the ground, Carol

Steckel. So without further adieu, let's have Robin set the stage for us. Thank you.

ROBIN RUDOWITZ: Thanks Diane and thanks again everyone for showing up and coming on this rainy day. As Diane said, I'm going to set a little bit of the context within which we're going to review the findings from our 50-state budget survey.

First I wanted to provide a brief reminder of the multiple and diverse roles that Medicaid has in today's health care system. It is, of course, an important source of coverage for many children and their parents as well as the elderly and disabled. The program provides assistance to low-income Medicare beneficiaries helping them afford their premiums, cost sharing, and deductibles to make Medicare work for them.

Medicaid is the largest payer and provider of long-term care services providing both community-based services as well as long-term care supports in institutional settings. Medicaid represents about $1 in $6 spent in the whole entire health care system, but a much larger share, about a third of revenues to our safety net providers and while we often think about Medicaid as a large budget item and it is for states, it also

because of the federal matching dollars for the program, it also represents the largest source of federal revenues to states and provides capacity in financing for states to carry out their coverage under the Medicaid program.

Again as another important reminder, we want to look at the distribution of both enrollees and spending on the program. While we know that children and their parents make up the largest share, about three-quarters of enrollees on the program, they represent about a third of the spending of the program, while the elderly and disabled who represent a much smaller share, about 25-percent of the enrollees in the program, make up over two-thirds of the spending on the program.

It would be impossible to understand and review the findings from our budget survey without understanding the fiscal context within which states have been operating their Medicaid programs for the last few years. Many say that states have really been experiencing the worst fiscal crisis since the depression. There's been persistently high unemployment rates.

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We've seen the worst drop in state revenues on record as well as increased demand for public services including Medicaid.

These factors have all resulted in unprecedented budget shortfalls at the state level. All states have really needed to make cuts both to their programs as well as to the state workforce to meet their balance budget requirements.

We also know that in an economic downturn, we see increases in both the uninsured as well as Medicaid and CHIP enrollment. Recent census data shows that the number of people who are uninsured in the country is now over 50 million people and new analysis, as Diane said, that we put out today, also in your packet shows a large increase, about six million people since the start of the recession have enrolled in the Medicaid program.

When you look at just the one-year increase in Medicaid enrollment from December '08 to December '09, you see an increase of 3.7 million people and that represents the largest annual increase in enrollment in the program on an annual basis in terms of absolute numbers.

In February 2009, Congress acted and the President signed the American Recovery and Reinvestment Act. That bill and law provided important fiscal relief to states in terms of about $87 billion of temporary federal fiscal relief by increasing the federal share of what the federal government pays for Medicaid. That relief was in effect from October 2008 and it goes through December 2010.

All states got an increase in their federal matching rates for the program and states that were experiencing high increases in their unemployment rate got some extra help. One of the important conditions for states in terms of receiving that relief was that states could not restrict their eligibility levels and they couldn't also make it more difficult for individuals to enroll in the program. Again, as you'll see in the survey findings, this assistance provided critical fiscal relief to the states as well as important protections on eligibility.

While states are still struggling from the lingering effects of the recession, they're also moving quickly to think about implementation of health reform. The Affordable Care Act

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enacted in March envisions a much larger role for states as well as the Medicaid program. The law really builds on the current roles of the program and expands coverage to nearly all individuals up to 133-percent of the federal poverty level. It really provides the foundation for new coverage as part of health reform.

Along with this new coverage, there's additional federal financing for that coverage as well as new options for states to think about delivering their long-term care supports and coordinating care better for those who are dually eligible for both Medicare and Medicaid.

So now I'm going to turn it over to Vern to really go through some more of the findings from the survey. As Diane said, this study represents a decade of work and partnership together with the Commission and Health Management Associates working on this. It does provide important results as well as the baseline for evaluating how states will respond and move forward implementing health reform.

VERNON SMITH: Well thank you Diane and thank you Robin. I'm very pleased to be here today. On behalf of the

incredible team of researchers and I really must echo the thanks that Diane extended to the Medicaid directors in these very difficult times or as one Medicaid director said in these "insanely" difficult times, we're especially grateful for their assistance in completing the survey.

The survey's conducted in July and August. The timing is intentional so that we can capture what states actually did in the prior fiscal year that, for most states, ended in June and to look at what states are doing in the upcoming fiscal year which, for most states, began in July.

The report focuses on what states are doing, what the trends are in enrollment and spending, the policy trends. We try to look at what states are doing to control their costs as well as what they're doing to expand coverage.

Aside from the economic downturn itself, the most significant force shaping Medicaid today has been the federal stimulus package, ARRA, which provided the enhanced Medicaid matching rate or FMAP to states. Clearly without the enhanced FMAP, the story we'd be telling today would be quite, quite

different. We would have seen cuts on a scale that we've never seen before if it had not been for this enhanced FMAP.

When Congress enacted this, it was intended to provide funds to states through Medicaid that states could use in Medicaid as well as to address overall state budget shortfalls. What we found in this year is that states use this money in a somewhat different way than they did last year.

Last year, states were a little more likely to use the money to address overall state budget shortfalls whereas this year with Medicaid increasing faster than expected, the state budgets' actually declining, states were more likely to use the money within Medicaid to pay for increasing case loads and to address Medicaid budget shortfalls.

Now when last year began, we described last year that states had authorized increases in Medicaid spending, 6.3-percent and in reality, when the year ended, the actual increase was 8.8-percent. The reason for that was a much larger than expected increase in Medicaid enrollment. The states had projected Medicaid enrollment growth of 6.6-percent

but in the end, Medicaid enrollment grew by eight-and-a-half-percent in fiscal year '10.

Now when states were appropriating or planning for their fiscal year '11, the current fiscal year, being somewhat optimistic perhaps, hoping for something of a recovery, the legislatures authorized spending increases for Medicaid of 7.4-percent for the current year. They expected that enrollment would grow by 6.1-percent.

Both of these are very robust rates of growth. If they materialize, they'll represent the first downturn in the rate of growth in a number of years but just as a note of caution, we always ask the Medicaid directors how likely do you think it will be that this will be enough or that there'll be a Medicaid budget shortfall and this year two-thirds of states indicated that they thought the likelihood of a Medicaid budget shortfall this year was about 50/50 and about a third of states said they thought that it was almost certain. So these initial appropriations may again prove to be somewhat optimistic.

Now there's a very interesting story that has taken place in terms of the state costs of Medicaid. From a state

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policymaker's perspective, it's the state costs, the state general fund costs, which is really important.

Because of the enhanced FMAP, for the first time in the history of the program, the state cost of Medicaid actually declined by almost 11-percent in 2009 and by seven-percent last year in 2010 but the enhanced FMAP was scheduled to expire in December of this year midway through the fiscal year.

So as states were authorizing or appropriating their funds for fiscal year '11, there was this great debate occurring here in Washington about whether the FMAP would be extended or not. This forced states to make a choice. Are they going to assume that the FMAP will be extended or not? It's a very consequential decision.

About half the states, a little more than half the states, made a choice to assume that the FMAP would in fact be extended. Those states then were able to authorize or to appropriate state fund growth of only five-percent but in those states, in the 24 states that did not assume an extension, they were required to increase their state fund share by over 25-percent.

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This is really significant because the enhanced FMAP will end now on June 30th of 2011 at the end of the current fiscal year. When states are making their budget decisions for 2012, we can expect to see virtually every state be required to increase its state contribution to Medicaid by one-quarter or one-third, or in some cases even more.

Now over the last year, states have done quite a number of things to constrain the rate of growth in Medicaid spending because state funds have been so scarce. Forty-eight states took actions to control the rate of growth in one way or another last year and 46 states this year have done so through actions and provider payments, eligibility, benefits or in long-term care. Now we'll talk about each one of these in turn.

When you look at provider payment rates, this by far is the most common action that states took. Three-fourths of states, last year and this year, took action to restrict or reduce the provider payment rate of one kind of another. The most frequent were in in-patient hospital where about two-

thirds of states froze or cut hospital payment rates or in nursing homes were about half the states did so.

The most difficult rate cut for a state to take is for doctors but last year, 20 states actually cut payment rates to physicians. It's a very significant action when a state does this because of its implications for access and participation in the provider community.

Now I note that last year at this time, 13 states said that they plan to cut rates for doctors but because of the ongoing fiscal difficulties throughout the year, as it turned out in the end, 20 states had to do so. At this point in time, 12 states say that they plan to cut rates for doctors in 2011.

Now on eligibility, the ARRA prevented states from taking actions to restrict eligibility. So the story here is one of expansion. In fact last year, 32 states, about two-thirds of the states actually took actions to expand eligibility and half the states also did things to simplify or streamline eligibility.

Now to be sure, most of these eligibility expansions were modest. About half the states took advantage of a new

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option in CHIPRA to extend coverage to legal immigrants, legal children, legal immigrants who are children or pregnant women. So that was a primary action that states took in this regard but there were a handful of states that actually did some very significant expansions.

Look at Colorado, Wisconsin for example, very significant expansions. Connecticut and the District have already taken advantage of the option in federal health reform to cover childless adults. Now the implication of renewal actions can be very significant. In Ohio for example where they adopted presumptive eligibility and 12-month continuous eligibility for children. They expect that to actually add coverage for about 41,000 children.

Now states seem to be more likely, this past year, to turn to looking at restricting or cutting benefits. In fact the 20 states that cut benefits in 2010 was the highest number recorded for this action in any of the surveys that we have undertaken going back to 2001.

Most of the restrictions and benefits were for optional benefits for adults- dental, chiropractic, podiatry, therapies,

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or in the long-term care side for personal care services and also it's worth mentioning that about 15 states also took actions for small increases but there's not a lot of money here, one way or another, for states but it's another measure of the depth of the fiscal strain in states that states are turning more frequently to these actions.

Now in long-term care, Medicaid is of course the primary long-term care payer in the nation. Medicaid covers all the services from those in the community all the way through services and the institutions. Over the last couple decades, it has been a regular phenomenon that annually states would expand the number of persons that they could serve in their HCBS waivers or expand the benefits.

As recently as 2008, three-fourths of states did so, 38 in 2008 but the last couple of years states just haven't had the money to do this. Fewer than half of the states have expanded their waiver programs.

Now there are many new options coming in long-term care that were provided in health reform and many states said that they plan to take advantage of the new state plan options or

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the incentives or the demonstration projects that are available in long-term care. Now with all of the actions that have taken place in provider payment rates and benefits, eligibility and so on, there's not a whole lot more that states could do in that regard.

States are turning increasingly towards system delivery reform. This seems to be where states can really make a difference. They're using managed care to a greater extent. One reason for doing this is that managed care provides a platform for quality improvement. States now are doing many, many things across the board in quality improvement.

In fact, quality's become a strong suit for Medicaid programs across the country with using the HEDIS and CAHPS measures to monitor quality, to use the performance that states, that their contractors have in these areas to reward performance through pay-for-performance programs and that sort of thing.

One of the things that states are clearly turning to is the use of health information technology, HIT, to enhance their quality improvement efforts. I assure you if you want to see

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excitement in the eyes of a Medicaid director, get them started talking about what they're doing in HIT to improve the performance of their Medicaid system. Now just to conclude here, we finish the survey each year by asking Medicaid directors what are the top issues that you see over the next year or so.

This year, two issues clearly emerged. One is there seems to be no end in sight for the fiscal pressure on Medicaid programs. This is an especially great challenge for Medicaid programs right now because with back-to-back recessions and the very difficult times of the last few years.

States have done just about everything they possibly can with payments, benefits, eligibility, and so on. This is one reason why states are turning to the system reform approaches to try to slow the rate of growth in the programs but this is clearly an issue and looking into fiscal '12, it's even more of an issue because of the big increase in the state cost of Medicaid that's going to occur in that year.

Now the second issue had to do with health reform and preparing for implementation. States see a lot of

opportunities in health reform. There are opportunities for reducing the number of uninsured, Medicaid expansions, working with the insurance industry and the formation of the exchanges. There are many challenges here relating to resources and because of the very short timelines but if these issues can be addressed and resolved, states are excited about the role that they can play in a new health care system of the future under health reform. With that, let me stop. Thank you.

DIANE ROWLAND: Thank you Vern and Robin. Now we'll turn to Elizabeth.

ELIZABETH KELLAR: That sets the stage very nicely for what we're going to talk about next, which is what's going on with the state workforce that has responsibility for not only dealing with the ongoing challenges of an increased Medicaid population but now also doing the heavy lifting that's required for implementation of the new health reform.

We looked, for this study; we interviewed top officials in five states. The five states are Connecticut, Massachusetts, Michigan, North Carolina, and Washington. These states were selected because they're geographically diverse,

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politically diverse. Some of them have governors who, because of term limits, must leave office.

Others have incumbents who will be staying on. So we thought that way it would be an interesting way to see what the differences and similarities might be in the way that the health care reform law is affecting them. We did all of our interviews between July 12th and September 1st.

So if anything's happened since September 1st and you don't hear it, that's probably why but we talked to quite a mix of people. We talked to people who had the policy leadership responsibility, people in finance, of course the Medicaid administrators who have so much responsibility for dealing with this, and people who were heading up the cabinet-led operations for the health care reform conversations.

What we found was that states have been moving quickly to set up planning structures to implement health care reform. This, interestingly enough, was going on fastest in the states where the governor was leaving office because I think they had perhaps a greater sense of responsibility or intensity to try

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to leave things in as good a shape as possible for those who followed them.

They all had set up structures to promote coordination across agencies. Something as massive as health care reform can't be done by just one agency. It involves so many different agencies that that's one of the critical steps that all the states in this study had undertaken.

The other thing that was important to many people about the coordinating activities was also making sure they had a process for stakeholder involvement because if you look at Massachusetts, which was one of the states that we studied, they recognized early on with their state law that they needed to bring in the private sector very early to set up their exchange.

So that lesson learned from Massachusetts has been taken to heart by all the other states and they're bringing in the private sector and doing a lot of other things that will have to engage the public, which generally has not fully grasped what's going on with health care.

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While I'm touching on that point, I think it just bares saying that these folks are so busy. They are so intensely involved not only with Medicaid enrollment issues that you've heard about but the deadlines that they have to meet for the September 23rd deadline.

To get all of those requirements in place, people have been putting in so much time and energy into it that it is noteworthy that they've been able to do it but they're a little bit worried that some of the longer term issues need more attention than they've been able to give to them at this point in time.

In all cases, we found that Medicaid directors and the insurance commissioners are playing lead roles in these advisory groups as you would expect. We, in this room, know pretty well that we have a lot of political transitions taking place this November.

At the state level, we know it's happening. We have, for sure, 25 new governors that will be coming into office because they're either term-limited or they're not running for re-election, so at least 25 to 37 altogether could change.

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So just imagine you have this new health care law that's got to be put into place and a lot of your leadership could well transition depending on what the next governor might view as the way to approach this. So these political transitions are affecting the pace and the challenges associated with health care reform. In addition to governors, bear in mind that our state legislatures also may change significantly. That may have an effect on what happens in the states as they go forward with implementing health care reform.

The factors that are important in terms of staff capacity at the state level are several. First of all, we have an aging workforce in state government. It's older, more educated than is the private sector. Anywhere from one-third to one-half of the senior people, in general, the people working in state government are eligible to retire in the next five years.

So if you think about that for a minute, you also have to ask yourself how much planning are we doing about this workforce challenge that's out there. Almost all persons, they

said gee we are going to do that in the next six months but we just haven’t had time to really focus on it.

A couple of states had, for example the state of Washington, had a state survey where they had clearly identified that 32-percent of their staff was eligible to retire in the next five years. So they’re just starting to get a handle on what their workforce needs are going to be going forward.

There are some challenges in state government just as there are with other levels of government about hiring practices and that came up in our interviews that sometimes there were barriers to getting people recruited that you wanted to have come in.

I talked to one state official who said he was trying to deal with one problem, which was in information technology by going to some of the graduate schools and actively recruiting there to try to bring talent in. So this civil service process requires some creativity on the part of state officials sometimes to get people into the pipeline that they need right now on the job today.

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You heard earlier about the effects of the recession on state government. You are probably aware of all the hiring freezes and furloughs and layoffs that have been taking place but this has been going on for years in state government. So some agencies have been affected less than others.

A lot of people who I talked to and my colleagues talked to in the Medicaid area said that Medicaid agencies hadn't been affected as much as some other agencies. They were already lean is how one person put it but in general in many agencies, the hiring freezes and the layoffs have been a factor.

One state official said that he had become concerned that because of this atmosphere, one of the attractiveness elements of working in state government, which is security, was no longer there and that in addition to not being able to compete on salary especially for senior level jobs, he also felt that it was a problem now because the people generally were thinking gee I used to think working for government was secure. Maybe it's not so secure. So that's another challenge that we're facing.

The relationship with the federal government is like most state and federal partnerships. It's always a challenge and the state officials that we interviewed said they really would like to have a true partnership with the federal government.

They feel sometimes that they're getting information from the federal government when they really want to have more of a dialogue. We saw some indications in conversations and activities after our report interviews were completed that, for instance, these forums that were set up with the National Governors' Association in Vermont and the state of Washington, those were an example of a productive way to bring people together to really air the challenges, identify the issues in more of a dialogue as opposed to kind of the usual way we get information out under tight deadlines, which is pushing it out and not knowing how to quite get a conversation going.

They're very appreciative of the federal grant money that has been provided and of course that has also challenged them from a workforce standpoint because guess what they don't have? Not so many people who can write grants. So just

getting on top of grant applications to get the resources they need has been another one of their challenges but I must say I've been impressed with how positive they have been about keeping their momentum going to secure the resources that they know they need.

When we talked to officials about what they thought some of their biggest staffing challenges were going to be, the number one was how to design the insurance exchanges. This is an area that they know even though it doesn't have to go into effect until January 1, 2014 that they've got to be planning and working on it now because there's so many steps involved.

There's system issues that have to be changed and anybody who's worked on a massive system problem knows you don't do that in six months or a year. It takes multiple years to do it. So they're aware of that. They're also aware that there may be competition for expertise because how many people have experience setting up a health insurance exchange? Probably not that many. So that's another concern that they might be in stiff competition for the resources that they need to get these exchanges up and running.

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They also have a lot of challenge dealing with the expanded enrollment for Medicaid and the state exchanges. This, in some cases, requires a lot of retooling of systems again. I would add though that they almost see the system as not a negative but almost a positive because some of their systems are antiquated and they're really hopeful that they could take advantage of the resources available to update and go online and make things more one portal operations.

They also have a big challenge to update their eligibility systems, which of course is required with the new law. So how are they going about this? This was an interesting conversation. They know that in some cases they're very comfortable relying on outside contractors.

They do that frequently when they hire actuaries or when they bring in information technology resources for certain kinds of jobs but in general, there was also a consistent theme expressed that what they really want to be sure that they have is capacity to provide ongoing support and manage this complex operation. So they were really interested in making sure that

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they could get enough staff onboard to handle that so they weren't totally dependent on outside contractors.

This echoes another point that some people from the private sector who had gone into government commented to us that they didn't expect to see as much dedicated, talented staff in state government as they encountered. They were frankly surprised, pleasantly surprised to find that. So what you would hear was yes we have the expertise that we need to do the job. We just don't have enough of it given everything we're trying to do. So there was a very consistent message about expertise is there just is not enough.

So were people gloomy? We're they disturbed? They were tired but I would say, by and large, they were upbeat about the possibilities. These are people, by and large, who want to see government work the way it can and should. So they saw health reform as an opportunity to restructure Medicaid eligibility determinations, improve program operations, and in some cases, we even had comments that we think we can improve health care. So there were consistently positive views about

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what might be possible because of the resources that are being made available.

The other comment that they all recognized is they are a little behind the eight ball on workforce planning. They know now is the time to look at their workforce needs. As I mentioned before, many of them had started to take a look at this but have been too busy to really get a handle on it but they're going to need that for the long-term. Thank you.

DIANE ROWLAND: Thank you. Carol, bring it down to earth.

CAROL STECKEL: Thank you Diane and the folks at the Kaiser Commission. This is one study, I have a standard response and some of you may have gotten this, when people ask if I can complete a survey unless it comes from another Medicaid director, it is due to staff layoffs or not layoffs in our state, due to freezes of hiring and due to merit system raise decreases, and our workload, we're not in a position to answer any survey. See our website.

The one exception is the Kaiser report and the work that Vern and the folks at HMA do because this is a critically

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important report for all of us to look at what each other is doing and what we could take from what other people are doing and move it to our states.

It also is encouraging because we're not alone. So when you look at it, you see that when you go home and you get in what I call my whiny cry-baby moods, it's not just you and get over it and get on.

These are, as a famous author said, the best of times and the worst of times. We do have horrific pressures on the Medicaid program and the timelines are unreasonable both for Medicaid programs and for the federal government. I don't think anybody originally intended it to be that way but it is the way it is but there are opportunities that out of this chaos and out of, I oftentimes think of the worst thunderstorms, some of what we'll see today, are the most beautiful rainbows. That's what we've got to keep our eye on the prize with.

You're seeing now, under our very eyes, a new Medicaid developed. That started back when Medicaid was delinked from the traditional welfare, social welfare programs. This is just

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a continuation of that effort. What you're seeing is some states are far down that transition.

So if you look at Wisconsin, New York, Massachusetts where Medicaid is fully integrated into the insurance market, into more of a private industry and I don't like that because state employees are good employees and caring and committed and thoughtful innovative people, but the private sector has more lee-way in doing things quicker.

So you see that kind of transition down to states like mine, which are just starting that process and being able to engage in a debate that we would not have been able to engage in absent this discussion of both the economy, the services we provide, how we provide them, and the need for health care reform for whatever that may look like after the November elections.

I don't think we can underestimate the transition in governors. That is going to be extremely challenging and will slow down a process that can't be slowed down but I'm not sure how to reconcile those two. What you are seeing states do is - and these, again are new ideas that come out of a crises - and

that's how do we band together to be better purchasers of services.

So you have 10 states working together with their MMIS contractor to develop the add-on benefits that we need for the HITECH act and for HIT in how do we buy it one time and divide it by 10 instead of buying it 10 times and it's the exact same product. So you're starting to see that type of work.

How do we go together with RFIs? How do we go together and do things that'll be both high quality and a lower cost for states? Not only are we looking at workforce development and how Medicaid programs now are needing different types of skill sets.

How do we retrain our existing staff but then how do we bring in the resources that we need to get through these next few years? The other component that is panicking most of us is that we're going to have, in Alabama alone, 500,000 new Medicaid only eligibles. That's on top of the million that we already have.

So if you're talking about 500,000 Medicaid eligibles and then you're talking about the premium assistance folks that

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haven't been insured, where are they going to go? So we're engaged in that debate with our provider community and for the first time - Alabama's not fond of managed care -We're very independent and we don't want somebody telling us where we have to go and do - but now they're starting to look at how do I organize, how can we give the power to the providers, but in a way that we have quality control, we have quality measures, outcomes measures.

Here's a novel idea, we'll pay you not for doing X service, Y service, and Z service but for this kind of an outcome and the providers are listening and participating in that debate unlike any other time I've seen in the past. I think that will bear tremendous fruit for the future regardless of what health care reform may or may not look like after November.

These are exciting times for Medicaid programs. If you see a Medicaid director, give them a hug because they are tired. We do tend to get a bit cranky every now and then but I think you're seeing a good dialogue as much as the federal rules and as much as the state rules allow between the federal and the state governments.

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It's just that everybody has these horrific timelines that, as I've told my folks, we're on a teeter board and every now and then, that teeter board balances but it's going to be rare because once we get a plan in the end, once we implement something, we get all the rules together, then there's going to be something else. So we're going to tilt back and then we'll get the CMS rules.

We'll be able to work with them. We'll be able to implement it. Then it'll be balanced. Then there'll be something else. It's that wave theory that we'll be experiencing and you have to respond to that both for your workforce and for your provider and advocacy community. Communication, communication, communication and I think you'll see more of that between the Medicaid programs, the insurance commissioners, and the general public in most states as we move forward but it is an exciting time.

It is a challenging time but I think in two years as we move toward 2014, when you look back at what Medicaid was today and what it will be in two years, it will be a dramatically different and a much more energetic, much more responsive, much more innovative program than it ever has been in the past.

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DIANE ROWLAND: Thank you Carol and I think Carol just gave us a new summary word for our budget report, teeter board [Laughter].

We want to thank our panelists but now we want to hear from the audience and take your questions and your observations about the report findings as well as any comments about what's going on on the ground from your perspective. If you would raise your hand and we'll get a mic to you and please identify yourself when you pose your question.

MIKE MILLER: Hi, Mike Miller, physician health policy consultant. I have a question for Vern about the changes in payments and reimbursements. Have the Medicaid programs done what Medicare's tried to do in the health reform bill and other people in terms of shifting to more primary care and sort of away from other more expensive areas and maybe specialty services?

VERNON SMITH: That's a very good question and provides an opportunity for an important observation. We focus on the cuts in provider payment rates that states have done but you notice on that same chart a large number of states are above

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the line doing positive things. What states have had to do, what they really tried to do is to target the changes in reimbursement.

So there have been targeted increases and where those occurred, they've been in primary care, preventive care on the evaluation management codes, that sort of thing or maybe targeting dentists to improve access for dental care, that sort of thing but yes, that's exactly what states have done is to really focus on where they can make changes that can help them get the kind of outcomes they want to encourage.

BILL GREGO: Bill Grego with the FHA 242 Mortgage Insurance Program for hospitals. Question on federally qualified health centers and it does feel like we're in the hurricane. I hope I come down with Toto. There's been a large financial expansion in federally qualified health centers, comments on is that enough. Massachusetts had an access issue. The ER costs rose tremendously in Massachusetts due to the impact, FQHCs, is there a bright spot there?

CAROL STECKEL: In my state, my chief of staff went to run the FQHCs in our state. So we have this very interesting

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dialogue going on about how much is too much and the fact that it is raining down like Manna from Heaven on FHQCs. I think for my congressional friends that are in the room, one of the things that has to be looked at is the reimbursement system for FQHCs. I think any time you reimburse any one at cost, you're going to have an inefficient system because there's absolutely no incentive to do it efficiently.

So that being said that, that's my political advertisement for my friends, but FQHCs are going to be the first step for that safety network in our state, in a lot of states for the 500,000 new folks and the uninsured folks, is it enough? I think it goes against the Medicaid directors' constitution to say there's enough federal money coming in to our states.

So my response is no it's not enough but what we need to look at is how do FQHCs fit into the entire health care system and maybe what we need to do is look at not just FQHCs but other clinics, other services, other ways for us to interlock the private sector in with the FQHCs, in with the Medicaid program and how do you make that work so that the

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FQHCs aren't getting such an advantage over the private sector that they're competing against it when you could build up a private sector system.

RODNEY WHITLOCK: Rodney Whitlock, Senate Finance Committee. Carol, by the way, are we on the internal web or CSPAN Ocho, what's the cameras for [Laughter]?

DIANE ROWLAND: Kaiser live webcast.

RODNEY WHITLOCK: Just checking, just wanted to make sure how broad [Laughter] the audience is before I—

DIANE ROWLAND: But it will be posted on the web and it is live right now.

RODNEY WHITLOCK: Never stopped me before [Laughter]. So Carol, I don't know if I completely got where you were going with the health center question because Dan Hawkins is going to see this and I'm going to hear about it but so what you're saying here is that you can't keep a federally qualified health center from participating right and that their reimbursement rate is significantly more than what you'll pay in the private sector. So effectively, your chief of staff took off to run a

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system that could drive your budget more so than you could possibly control. Is that what I think I heard you say?

CAROL STECKEL: That is exactly what I said yes, yes and let me add a comment here, there is a need for federally qualified health centers and rural health centers. They provide good work. I just don't believe that when you do all of that that every player in the market has the incentive to be efficient if it's cost-based.

EILEEN SIPPER: Hi, Eileen Sipper with [inaudible] Consulting. Question to the panel about cuts in provider payments. Have we drilled down into what the impact is going to be specifically on the physician administered injectible products and what are you seeing across the states? What are some of the changes in reimbursement, benefit restrictions, and so forth that the states are implementing to help control costs?

VERNON SMITH: Well first of all, I can't speak to the injectible reimbursement issue. Some of the states may have mentioned that but it wasn't the sort of pattern that we picked up in any consistent way across the states.

On the benefit side, the position that states are in is that they really have to look at every possible opportunity to slow the rate of growth in Medicaid spending. They're under such intense fiscal pressure from their state budget director and from the legislatures. So they're looking at every possible option and that's the reason states have looked at benefits.

As I mentioned, the benefits that states have looked at, the most frequently restricted or cut benefit has been adult dental services and also other optional services such as chiropractic, podiatry, and some of the therapies and so on but there's just not a lot of money in this. I think legislatures and state administrators look at this because they know that it's important for everyone to know that they're doing everything possibly that they can do.

CAROL STECKEL: We mention, not specifically about physician administered drugs, because my pharmacist would tell me I'm speaking beyond my scope of knowledge but Alabama just received approval from CMS and I think we're going to be the first state of many states that will do this switching from

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AWP, Average Wholesale Pricing, to Average Acquisition Cost Pricing and invoice-based pricing, which make no mistake about it, we're still not getting down to the actual acquisition costs but we're getting close to it.

By doing that, we did invoice pricing to get to AAC. We increased the dispensing fee from $5.40 per prescription to $10.64 and saved $30 million. Now I'm telling you all that shows you, and I've got all sorts of evidence from discovery of our lawsuits against the drug manufacturers, about how much Medicaid programs are being overcharged for prescription drugs in this nation.

I think that's where you'll see states really start to chalk up some savings where you're taking it out of the profit margin but not out of the cost of doing business side. So I think you'll start to see a wave of those changes.

DIANE ROWLAND: Next question.

EMILY KATZ: Hi, my name is Emily Katz. I'm with Care Oregon. I hear the phrase federalization of Medicaid tossed around a lot these days and I was wondering if you had heard any of that tension or that push and pull described from the

states that you had interviewed or I was curious maybe to hear from that state perspective, the 100-percent of federal match for the first few years.

So I'm just hearing that phrase, the federalization of Medicaid, so I was wondering if any of the panel could speak to that. Thank you.

CAROL STECKEL: I think on any MD's part that is a natural tension and then you've got two kind of polarized camps. You've got the camp that's been working very, very, very hard for many, many, many years to have 100-percent universal coverage, all payer, all coverage for individuals, which is an honorable goal.

Then you have folks that I teasingly refer to as the realists, those of us that realize what our states can do, what they're capable of doing, what they're willing to do, and what we can expend resources on.

So you have that natural tension and there are people along that continuum also. So I think you've now got a built-in tension where if they decide that the basic benefit package for the exchanges, which by the way, is also the basic benefit

package for the Medicaid program, is more inclusive than what the required benefits are for Medicaid.

Now you're going to add to the cost of the Medicaid program and even with 100-percent reimbursement, it's only for two years and then it goes down and this is on top of budget shortfalls of horrific natures in 2012. That's what the budget legislatures are going to be dealing with when they come in, congratulations you've been elected governor, oh by the way in 2011.

So I think you've got that natural tension of how do we get what we want. We want all coverage of all services, EPSDT-type, from we can't pay for what we've got know, how are we going to do that on top of the 500,000 new people but that's a healthy tension most times.

DIANE ROWLAND: I might add one thing from listening and some of the discussions about implementing the Affordable Care Act. It's the first time I've heard states say we'd really like more federal guidance rather than less. We'd like you to be clearer about some of the implementation things.

So I think that dynamic is really a very changed one from what we might've seen five or six years ago and as you look at the staffing capacity issues having better and stronger guidance about where to go forward from the federal government may make the implementation a little smoother because it looks kind of rocky without some guidance there. Vern, I don't know if you want to comment as well.

VERNON SMITH: Sure, I would add toe this discussion from Medicaid directors as we conducted the survey but one of the things that really came through very clearly is that there are options in federal health reform. What we really heard states, talking about was well there are these options to do this, options to do this.

There are demonstration projects. There are, in long-term care, some opportunities for enhanced federal matching as states move to rebalance their long-term care system. There's just option after option after option for states to consider.

The frustration that states had was that they don't have all the staff and they talked about how they'd have to be very careful in their allocation resources because they

actually don't have the staff to do everything they might otherwise want to do but yes, as Carol said, I think there is this healthy tension. States want to do these things but there are resource constraints that are genuine.

NELL GEISER: Hi, my name is Nell Geiser. I'm with the Change to Win Labor Coalition. I wanted to follow up on Carol's comment about the cost-plus innovative program that you guys have implemented and Oregon is about to put that into place as well for prescription drug reimbursement and what kind of momentum there is.

If you could just say a little more or Vern as well for cost-plus pharmacy reimbursement systems or what other measures have the most momentum to reign in pharmacy drug costs in Medicaid programs right now and what's practical for states to implement in the near-term if I think you guys put in quite a bit of effort into that lawsuit over a few years and then the survey and everything that had to happen in order to put a cost-plus system into place.

CAROL STECKEL: The lawsuits were independent of the work that we started. It's just when you sit in a courtroom

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for as many hours as I had to do, one if you sit still that long, which is impossible but two and you see the disparities between what the wholesalers are charging and what we were paying, I mean it made me physically ill. Then I'd have to call my pharmacy director and yell at her and it wasn't her fault. So we really saw in real terms what we were overpaying.

So net every cost, we're saving $30 million. So that's net of our contract cost. That's net of the upkeep of the drug pricing files. That is everything related to implementing AAC absent our costs, the agency costs. So it just shows you kind of and we're a relatively small state. Now I think you'll start to see states looking at when you look at outcomes measurement, I know we've implemented some work around the issue of anti-psychotic medications in particular when it comes to anti-psychotic medications for young children.

I mean I think there's some vulnerabilities there that we need to look at and to improve how we provide the needed care but make sure that the kids are getting the services that they need. I mean I am not a psychiatrist. I don't even try to play one. Many people say I need one [Laughter] but the

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thing that worries me is we've got two-year-olds on two or three powerful anti-psychotics and I don't understand it. I haven't had a medical doctor be able to explain it to me.

So I worry about that and I think you're seeing and I know for sure, you're seeing groups of states get together the medical directors and look at that issue. I think as we move to outcomes measurements, the whole idea of the high cost drugs and are they right, are they wrong, are they doing what we need to do, and then the peer-reviewed studies showing that the newer drugs are not necessarily any better than the older drugs. So I think you'll see a lot of work on the pharmacy arena.

NICK BACHE: Good morning, my name's Nick Bache. I'm also at Hospitals Underwriting with Bill, but I'm also the son of a 30-year solo practice primary care physician in rural Louisiana.

So my question is one of access and with the proximity of all the directors that you spoke with and are, do you feel with the upcoming budget crunch the continued decreased reimbursement wholesale to physicians, I feel like it's

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creating kind of an emotional backlash against the Medicaid program that I worry about. I'm wondering what your thoughts are on that kind of movement.

CAROL STECKEL: I know most Medicaid directors are looking at, again with the idea that in 2014, we're going to have huge volumes of people added to the program much less that we're looking at how we organize the system, and I know in our state, the mantra's become you've got the patient in the center and then you've got that primary care connection whether it's a physician, an FQHC, whether it's another type of clinic, how can we surround that linkage with the tools they need to better provide the care to that patient – so things like EHRs, we've implemented EHRs in our state.

How do you do distance management? We don't have very many adolescent psychiatrists. So we've started a telemetry program with adolescent psychiatrists in our two university medical schools, which will help the primary care doctor in the rural community. So I think that's what you're seeing in most Medicaid directors' minds is how do we build that linkage between the patient and a primary care medical home?

Everyone's heard that term and then how do we build that medical home.

In our state, we've moved to a medical neighborhood. So how do you build the pharmacist into that community? How do you build the dentist? How do you build the other services, again, into that medical neighborhood with outcomes measurements to better care for that patient and to make it easier. You talked about HIT initiatives and all of that, how do you make it as administratively easy for the physician in that community? That tends to be the thought process for most Medicaid directors.

VERNON SMITH: If I can maybe just add one quick thing to that. There has been a good deal of discussion about whether there will be access issues with this large number of people coming on to Medicaid under health reform. I think the forecast or the projection is that maybe 30 to 40-percent growth in Medicaid over the next decade related to the expansions to Medicaid; 30 to 40-percent, which is significant. I think it's enough to cause us to pay attention to the access issues but we do need to keep this all in perspective.

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When you look at the growth over the last decade, Medicaid enrollment grew by about 58-percent overall, and the decade before that by about 80-percent. So if we're looking at a growth over the coming decade of increases in enrollment are 30 to 40-percent, at least we have seen that the system has been able to absorb that kind of an increase in the past without decreases in access that resulted from it.

ROBIN RUDOWITZ: Just one other point to make that is part of health reform, there are provisions that would increase provider payment rates and Medicaid particularly for primary care to increase the Medicaid rates to the Medicare levels starting in 2013.

JAY POWELL: Good morning, my name is Jay Powell. I'm an independent consultant. This question is for Elizabeth or Carol. It's about insurance exchanges. If you could fast-forward to January 1, 2014, what would a well-functioning insurance exchange look like? What are the keys? What should we expect? What type of efficiencies, if any, in terms of relief to states can one expect, and are there any best practices that exist today?

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DIANE ROWLAND: I think you just asked for a whole separate briefing [Laughter].

ELIZABETH KELLAR: The one thing I would say is that a state that's off to a good start in some of the mechanics, in any way, is Massachusetts and that's why a lot of people are looking at how they set it up. The other thing I would say is if it's really functioning well, it becomes a marketplace where we, as individuals, and small businesses can go and shop and understand what we're getting and make informed decisions. So that would be my simple answer.

CAROL STECKEL: Let me tell you very quickly and I'll talk very fast because if everything went right and we got all the support we needed, what you would have is one eligibility process for every health and social service program that would go up the exchange because if you're going up to 400-percent of the poverty level, why not let that workforce make the determinations?

Mrs. Smith you came in for health insurance. You're at a premium assistance rate of 138 or 139-percent, did you also

know you might be eligible for SNAP or you might be eligible for this or for that?

Would you like to continue that application process and then have again the technologies there, have that decision tree happen so that you don't have to have eligibility workers in Medicaid and DHR public health and talk about all the other programs including community programs but if you have that functionality then not only can you marry it with the marketplace but then you've got everything being determined through one eligibility process.

You've got the potential for efficiency because you don't have to have as many staff and if you let the technology work more for you on how that process works, your training is better. Your turnover is less. So you've got a stronger workforce there that knows what they're doing and then you can focus on case management around that eligibility decision.

VERNON SMITH: And if I could just add to that, as we listen to Medicaid directors in our survey, we had a question on this about the vision that they might have. This is exactly the sort of thing, which we've heard all across the country

especially with the standardized definition of eligibility and the new standardized definition of income, accountable income in determining eligibility. So there's a potential to do this, which is there. The question now is how you actually put that into practice.

BILL GREGO: Just one last question, an issue, it was addressed at one of the main stressor points for the Medicaid directors across the U.S. is they're worried about the creation of the health insurance exchanges themselves.

I really feel those kind of answers are here in the room rather than there and they will be forthcoming but is there not a national association of insurance commissioners with very high panel group, with leadership that's already been demonstrated in developing these regulations, proposed regulations, and already handing them to the fedswith input? Do you trust them? Are they on our side? What do you think? Aren't they being written right now as we stand there?

CAROL STECKEL: The National Association of Insurance Commissioners has a phenomenal staff. Brian Kelly, I believe is his last name, is the, Brian Webb, I apologize, is the

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Executive Director, and we are working very closely with them but you've got insurance people and their language and their programs and you have Medicaid people and their language and their programs. So right now, we're working with an interpreter. We're working very well [Laughter] together and that dialogue is ongoing and you've got two basic functions too.

You've got the insurance, traditional insurance, stuff like how do we compare plans? How do we make sure that the medical loss ratio is the right way, all of the kind of insurancey stuff? Then you've got this thing called eligibility, which insurance commissioners don't normally do but that dialogue, at the national level and at the state level, is going extremely well and one that I think if you asked each individual Medicaid director privately, they may have a different answerdo you trust them. But you've got another added kind of twist in that you've got appointed Medicaid directors that work for the governor nine times out of 10 and insurance commissioners could be elected in their own right, appointed by the governor, appointed by commissioners.

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So there's all the political dynamics but the dialogue is ongoing and is very, very good.

BRIAN BLASE: Hi, my name is Brian Blase from the Heritage Foundation. I was struck by your figure that state Medicaid spending's going to increase 33-percent next year. I was wondering what states - this election cycle's going to produce governors and legislators who are going to be very hostile to increasing taxes to deal with that increased state spending - what are the states going to do when spending next year is going to increase 33-percent? It seems like the big area that they're going to have to cut is education spending. That's the other, in addition to Medicaid, that's the big component of state spending. Thanks.

VERNON SMITH: Well Medicaid directors are hoping for recovery. This is a big issue. The arithmetic is very simple. When the federal matching rate goes back to the base FMAP rates in July of 2011, the state cost Medicaid is going to go up by one-fourth to one-third depending on the state. That is going to happen.

It is going to put enormous pressure on state budgets because for three years, states have had this high federal matching rate and a lower state contribution to Medicaid. So it's an issue that legislatures are going to have to deal with in January. It is going to force states to make some very difficult decisions.

RODNEY WHITLOCK: I want to, particularly following up on that, because I think it is really relevant to the overall topic here, and I want to make an argument here and get your reaction to this that, Rodney Whitlock, Finance Committee and I've already gotten an email from the Community Health Center, so they are watching today [Laughter].

You've said what? That's not true. For the purposes of state budgets for the next decade that Medicaid is largely bulletproof now post-health care reform and that the ability to really touch Medicaid within a state budget is extremely limited. I mean Carol, if I come to you as the governor upon going through inauguration there in lovely Montgomery and I come to you and say okay, let me lay out my budget here, look at all my options, what can I do in the Medicaid space?

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Now tell me the ones that we can actually do on our own. Tell me the ones that we have to go "mother-may-I" to CMS of which they will most certainly say no and tell me what can I actually do. If you look at those, you've got nibbling around the edges with provider payments, which are counterintuitive to providing care.

Okay, cut adult dentistry right, then you've got a bunch of people running around with a big look of British smiles. I mean you've got, that's a Simpson's reference, or you can prove that you want to provide less care by cutting providers to the point they refuse to participate or you can get incredibly draconian and go to like let's see, how much of long-term care is actually an optional service.

I mean unless you're willing to go very long, make the case to me that I'm wrong that Medicaid, as a portion of a state budget moving forward for the next decade is not with the eligibility mandates moving forward, with the eligibility growth moving forward, is not bordering on bulletproof.

CAROL STECKEL: I think you're exactly right. In some states where they are now, we do a budget cut book and to your

question too that I just update every budget year and hand it to the current governor and the current budget office and say I've listed my priorities of how I would cut it but you have to make a decision and it is changes in nursing home reimbursement, which we tend to be very generous in our nursing home reimbursement but it's also political dynamite.

So you've got that. Then you go to some very challenging, do you want to eliminate hospice programs for non-institutionalized individuals, eyeglasses, vision for adults? Do you want to end the breast and cervical cancer program, which is optional but when you've had a woman turn to you at a hearing at the legislature and say thank you for your program, I am alive today because of your program –that's when it gets personal and you see the results of what you're doing.

So that's a program that we could cut. We could cut renal dialysis for patients. How long do you think someone could go without dialysis? That's the kind of cuts that we're facing. I think when you move into 2014, it locks in the Medicaid program.

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Then what you do is you start looking at how are we organizing the care? Can we provide, whether we call it pay-for-performance or incentives, shared savings is what we do in our state, can we create systems that pay for outcomes? Can we do that kind of thing? The pharmacy reimbursement change stunned all of us that we came up with those savings. So I think it's going to be a challenge.

That's why I laughingly say when our new governor gets elected and, ironically, it very well may be a retired dermatologist, so we'll have a doctor in the governor's house, but congratulations, you just got elected governor, no going to Disney World because I have a $64 million shortfall because of the stimulus shortfall that was budgeted, $50 million every year regardless of what goes on just for inflation. Then by the way, there are these added things that we need some money for. It's going to be a challenge.

ROBIN RUDOWITZ: Just a reminder that the Medicaid program is this countercyclical program and a dominant driver of Medicaid spending is enrollment. So we've seen enormous pressure on the program because of the recession-driven

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enrollment in the program and as states begin to see the economy recover, those pressures on enrollment will decrease.

I don't think there's any doubt that Medicaid directors have really pushed the limit on some of the other mechanisms to save money in the program but again, enrollment is the main driver. Then looking forward to 2014 when the new enrollment expansion requirements for Medicaid kick in, states will also see large amounts of federal revenue coming in alongside with those new requirements to expand coverage. So those are some of the balancing factors they're looking at.

CAROL STECKEL: Let me mention again for our captive audience because I know they can't get out, administrative costs weren't put up at 100-percent just for the record.

ELIZABETH KELLAR: I was just going to say the fiscal issues for states are huge and even before the recession hit us so hard, states were looking at big drivers in terms of growth and costs in corrections, health care, education. In the case of health care, even before the law passed, you had a lot of states who were looking at ways to bend the cost curve.

So there's a lot of innovation out there in terms of medical homes, looking at instead of putting people in institutions, seeing if there are alternatives to care for them at home. I think there's a lot of energy about costs, wellness programs that can help in the overall picture of how we manage our health care costs.

VERNON SMITH: Maybe just add to that, one of the things that states are looking at within health reform, there are all these opportunities for system reform with global payments, bundled payments, accountable care organizations, special disease management programs for persons with chronic disabilities, and that sort of thing.

I think there's really an expectation that the promise of the future is with these approaches to redesign the delivery system and bring some organization and structure to it and that the big payoff of the future may be in those kinds of initiatives.

Aaron TRIPP: Hi, I'm Aaron Tripp from the Hilltop Institute. You've talked a little bit about some of the long-term care possible expansions. I was curious with the state of

the state budgets, a lot of those were designed to be state plan services.

So I know some of the states that we work in, there's been a lot of concern about not having some of the controls that waivers do for those expansions. What's sort of the lay of the land of how people feel about the take-up of some of those possible enhanced matches but without sort of having some state level control on the spending growth?

VERNON SMITH: Yes that's a very important question. There are some important opportunities in long-term care, state plan options, special incentives, demonstrations, and so on that can help a state rebalance its long-term care system.

We did have some states say, "you know we'd really like to do that but we don't have the funds to do it," because the state plan option might, as a state plan, doesn't allow the state to have some of the limitations on the number of people that could be served and that kind of thing. I think we may need to wait until times are a little bit better before all the states who would like to take advantage of these options will actually do so.

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DIANE ROWLAND: Well I think we're all waiting for times to be better but I think today we did look at the teeter board and the balancing act that is going on in the states between the program today and maintaining that and managing through tough economic times and preparing for the future when there is a new Medicaid developing. I think that we will continue to want to track this to look at what some of the changes are.

Again, I want to thank all of the state Medicaid directors who helped participate and the others who helped in our study to be interviewed as well as our panelists and thank you for coming out in the rain, which looks like it's getting even worse instead of better so that on this gloomy day, we've seen a little optimism and a lot of good information. Thank you very much [Applause].

[END RECORDING]

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