



**Medicaid 101: What You Need to Know
The Kaiser Family Foundation
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ED HOWARD: Good afternoon, my name's Ed Howard. I'm with the Alliance for Health Reform and I want to welcome you on behalf of Senator Blunt, Senator Cardin, our Board of Directors, to this program today on the basics of Medicaid. Now today's briefing is the second in a series of primers that the Alliance and the Kaiser Family Foundation do near the beginning of each new Congress. Two weeks ago we did one focusing on the Affordable Care Act. Next Friday on the House side actually, we are going to be doing one on the basics of Medicare. And then the following Wednesday, April 1st, the final one in the series on healthcare costs. But today we want to focus on Medicaid. Who it serves, what services it covers, what it costs, and who pays that cost. The idea is, as I said, just to give you the basics of the program so that when the disagreements begin, as I am told that there have been in the past, more people are going to have at least a common set of facts undergirding their understanding of the program.

So we start – I just want to make a couple of observations about Medicaid. We talked a lot about Medicaid actually in the ACA primer a couple of weeks ago because there were a number of important changes made to the Medicaid program in that law. But after all, Medicaid has been around for 50 years now. There was a lot of history. There is a lot of ongoing activity in Medicaid independent of any connection to the ACA. It's huge, that is to say Medicaid is huge, both in terms of the numbers of people enrolled and the dollars spent, both federal and state dollars, of course. Second, Medicaid's traditionally served several different specific constituencies in its beneficiaries – children and pregnant women, poorer Medicare beneficiaries, those in need of long term services and supports specifically. And if you didn't fit one of those categories, and I certainly didn't name anywhere close to all of them, but if you didn't fit in one of those categories, it didn't matter how poor you were, you couldn't qualify for Medicaid coverage. So third, I guess, is that while some states do raise objections to what they see as rigid federal regulation, there is truth to the bromide that when you have seen one Medicaid, you have seen one Medicaid program. And we'll talk a little about that variation over the course of this afternoon. As I said, we're joined in bringing you this program by the Kaiser Family Foundation, one of America's most trusted voices on health policy issues and a source for more good information about Medicaid than you're going to find anywhere else. One of its most respected initiatives is the Commission on Medicaid and the Uninsured, and we're pleased to have as a co-moderator today Barbara Lyons, who is both a Senior Vice President of the Foundation and Director of that Commission. Barbara, thanks for being with us today and thanks for the Kaiser Family Foundation's support of these primers.

BARBARA LYONS: Great. Thank you, Ed. I just wanted to say thanks to Ed and to the Alliance for Health Reform for partnering with us on these Alliance one-on-ones to provide the basics on the Medicaid program. And I would also like to thank the other panelists who are here today who are among the top experts on Medicaid in the country. As Ed said, Medicaid turns 50 this year. I think the roles that it plays in the U.S. healthcare system and for the people that it serves often go unrecognized so I'm particularly happy to have this time to go over the facts about who the program serves and what it does in the U.S. healthcare system. The Kaiser Commission on Medicaid and the Uninsured has been around for the past 25 years. So we've spent a lot of time over the past several decades analyzing Medicaid and trying to bring information about the program in a way that is easy to understand for people who are making decisions about the program's future at hand. I want to draw your attention to one of the documents in your packet, *Medicaid Moving Forward*, which is our most recent update on the roles of the program and the rules in the program on who it covers and how its services are provided and how its financed. And I just want to make one point before

turning back to Ed. And that's that Medicaid is not a static program but since the program was enacted along with Medicare in 1965, Congress and the states have reformed and expanded the program in considerable ways over the past several decades. I don't Tweet very often, I'm told, but one of my Tweets was it's not your grandfather's Medicaid. And I think that's absolutely true. And so you should take a look at it and really come to appreciate all the roles that it does play in society. The program has evolved as the nation's needs have evolved and I'm pleased to be here today. Thank you.

ED HOWARD: That's great. Thank you, Barbara. And if you want to Tweet, there is a hashtag. #Medicaid101. If you need to get on to Wi-Fi in order to Tweet, you can see the user name and password credentials that you'll need to do that up on the screen behind us. Let me do a little bit more housekeeping. There's a video recording of this briefing that will be available probably Monday, thanks to our colleagues at the Kaiser Family Foundation on their website, kff.org. There will be a transcript a couple of days after that on our website at allhealth.org. And at that same website you can find, and actually at the kff.org website as well, all of the materials that you find in your packets are online at those websites, along with a one page materials list that goes well beyond what you have on paper. We save trees and educate you at the same time. Two things to look forward to. If you have a question that you want to ask and that's the whole point of these exercises, particularly the primers, don't worry about it being too elementary or too complicated, given the sophistication of this panel. But you can either write it on a green card in your packet or to go one of the microphones in the aisles and verbalize it. And finally, there is a blue evaluation form in your packet that we would be just delighted if you would fill out. And particularly if you're a member of the Congressional staff. We understand that turnover is high. You may be new to this subject. We want your opinion on what we should be doing to help educate you. And if I can take 30 seconds for a commercial that is related to that, many of you on Congressional staff working on healthcare received an email from, I guess it was directly from SurveyMonkey, asking you to fill out and a health reform health policy questionnaire. You can see the reference to it on the slide. If you would dig it out of your spam folder and fill it out, it takes about five minutes. And if there are people in your office who don't normally come to alliance briefings, we want to hear from them too, so feel free to pass it along. Enough. We have a terrific panel, as Barbara alluded to, and we are going to start with Robin Rudowitz, who is the Associate Director for the Kaiser Commission on Medicaid and the Uninsured. Robin has analyzed and overseen and had a hand in operating the Medicaid program at both federal and state levels and in the private sector. And today we've asked her to give us an overview of this complicated program. She is as good as anyone at translating those problematic complexities into English so Robin, get us started. Thanks very much for being with us.

ROBIN RUDOWITZ: Thanks so much. It's great to be here and thanks, Ed and Barbara, and everyone who stood up to the weather and stepped away from their computers watching basketball to come to the briefing. I will echo, I think, what Ed and Barbara just said about this being an exciting time to be talking about Medicaid, as the 50th birthday approaches in July. And there's been so much evolution of the program from one that was really designed to serve elderly and blind, as well as children who were on welfare, to a program that now serves one in five Americans. So with that quick backdrop and my clock not even started yet, I'm going to turn to try to provide an overview in the next ten minutes or so.

So this slide really attempts to capture the many roles that Medicaid has in the healthcare system. First and foremost, it is the nation's main source of coverage for low income people. It covers about 70 million Americans, traditionally providing coverage for children, their parents, as well as the elderly and individuals with disabilities. The ACA, of course, was designed to broaden that coverage to fill in gaps for adults. Medicaid also provides assistance to low income Medicare beneficiaries to really help make the Medicare program work for them in providing assistance in paying for premiums, as well as covering services that are not covered by Medicare, particularly long term care. And Medicaid is really the primary payor for long term care in the country and it accounts for one in six dollars spent on healthcare services in the country. So it's important for long term care but also for safety net providers and clinics as a revenue source. And Medicaid also provides important assistance to states in providing dollars and resources for coverage. If we dig in a little bit deeper to who's covered by the program, we see that because of the historic eligibility levels for Medicaid, the program plays a key role in serving specific populations. It covers more than a third of children in the United States and seven in ten kids in poverty. It finances nearly half of all births. One in five Medicare beneficiaries are also covered by Medicaid and it covers two thirds of nursing home residents.

So turning now to what is the program cost and where do the dollars go. I think it would not be a Medicaid 101 presentation with someone from Kaiser presenting without showing this really essential slide. And if you don't know much about Medicaid and you remember one thing about the program when you leave, it's probably this slide. This is about who the enrollees are and where the spending is. And you can see from the slide that children and adults account for about three quarters of the enrollees on the program, but the spending is really heavily allocated to the elderly and individuals with disabilities. And they account for about two thirds of the spending on the program. These populations have higher healthcare needs and utilize more complex acute care services as well as long term care services. If we look a little bit about where the money goes by service, we see that about two thirds of the spending is for acute care services with a large share going to managed care organizations. And about 30 percent of the spending on the program is for long term services and supports. There's a small share of spending that's for DSH payments, which are special payments for hospitals that serve a large number of Medicaid and uninsured.

So this slide is really just a jumping off slide to talk about the financing of the program, which is shared by both the states and the federal government. The federal government provides federal matching dollars to states when they pay for spending on the Medicaid program. And there's no cap to the federal dollars on Medicaid spending. There's a thing called the FMAP or the federal matching percentage and that's set by a formula that's in the law. And it's based on states' per capita income and it varies across the states and it is adjusted annually. So there's a minimum of 50 percent and it goes to about 74 percent in a state like Mississippi. Because of this joint financing and the way that the federal matching dollars work, Medicaid is both an expenditure item for states as well as a source of revenues. And when we look at state budgets nationally, we see that Medicaid accounts for about a quarter of all spending in states. But if you dig a little bit deeper and look at what states spend of their own money, so their general fund dollars, that's less, about 18 percent. And Medicaid accounts for the largest portion of federal dollars that come into states. So states have a little bit of flexibility in terms of how they set their benefits. So within the program rules, they can determine what benefits they'll cover, as well as the scope of those benefits. And they also have a great deal of flexibility to determine how those benefits and services are provided to beneficiaries.

States have increasingly relied on managed care to deliver care to the Medicaid population. There are now about two thirds of the Medicaid population in some type of managed care arrangement and that includes primary care case management in those totals.

I think over the years there have been some concerns about provider participation in the Medicaid program. And this slide shows that despite concerns about participation, data consistently shows that Medicaid coverage increases access to care for both children and adults. Medicaid beneficiaries are much more likely to have a usual source of care and they are more likely to get the care that they need, certainly compared to those without insurance. And the access is comparable to what is provided in private insurance. Because the law limits the amount of premiums and cost sharing that states can impose on beneficiaries, it also provides important protections for beneficiaries in terms of catastrophic medical expenses. And there's a lot of other data, particularly for kids that looks at the linkages of coverage to positive health outcomes, reductions in hospitalizations, and also gains in education for kids. As we discussed a little bit earlier, Medicaid really does provide broad coverage for children. More than half the states have eligibility levels set for children that are at or above 250 percent of the poverty level. But coverage for adults through Medicaid has historically been much more limited. So prior to the ACA, low income adults without dependent children, or childless adults, were typically excluded from coverage and coverage levels for parents were very low, much lower than for children. So the ACA fundamentally reformed Medicaid by establishing eligibility for nearly all adults at a national level of 138 percent of the poverty level. That's about \$16,000 annually for an individual or \$28,000 annually for a family of three. And the law also provided states with a significant amount of federal dollars to support that coverage, paying for 100 percent of those costs in 2014 through 2016. The Medicaid expansion was designed to be implemented nationally, like coverage for kids, but the Supreme Court ruling effectively made it an option for states. And this map shows that to date, we see 29 states including DC that have adopted the expansion. It also shows that there are a number of states that in their legislative sessions right now are still actively debating whether they should implement the Medicaid expansion.

So in states not implementing the Medicaid expansion, we see that median coverage levels for parents remain very low, about half of the poverty level. And childless adults are generally not eligible for coverage. What this means is that there are a lot of individuals in those states who fall into a coverage gap so they are not eligible for Medicaid but they're also not eligible for tax credits to help them purchase coverage in the marketplace. And we estimate that about 4,000,000 people fall into that coverage gap. So the ACA extended coverage but it also made major and significant changes to the way Medicaid enrollment processes work. And this was effective across all states, regardless of whether states implement the Medicaid expansion. And new systems were designed to allow individuals to apply through multiple ways and to utilize data matching so people didn't need to provide paper and also much quicker eligibility determinations. And I know Tom will talk about this more, but there's a lot of focus on the ACA, but states are really highly engaged and focused on a whole number of payment and delivery reforms that are happening across states as well. States are continuing to implement and expand managed care and also a whole array of other delivery system reforms, including patient center medical homes, health homes, initiatives to integrate coverage and financing for dual eligibles, and a whole array of these reforms. And states are, of course, continuing to expand community based options to provide long term care services to individuals in the community rather than institutions.

So with that, I'm just going to wrap up with a few notes. So largely due to the ACA, we see Medicaid enrollment has been increasing and there's also been significant progress in moving towards transforming eligibility systems and enrollment systems. We know that Medicaid coverage increases access to care from lots of data. We also have polling data that shows that Medicaid beneficiaries have positive experience with the program. I think in the past, especially during the recession, there were many states that were highly focused on cutting the program and controlling costs. And while that's still a focus for states, they've been able to really focus as well on more delivery and payment system transformation. And we will continue to watch lots of key issues as the Congress develops their budget and we'll see what happens with the economy, the debate around CHIP and the ACA implementation going forward.

ED HOWARD: Terrific. Thanks very much, Robin. A world wind but very illuminating tour of that complicated program. Next, we're going to hear from Tom Betlach, who is the Director of the Arizona Medicaid program, which is known as the Arizona Health Care Cost Containment System, sort of forming the acronym AHCCCS.

THOMAS BETLACH: It does form the acronym. We talk about access with two Cs or three Cs.

ED HOWARD: He also happens to be the President of the National Association of Medicaid Directors. Tom's been a senior official in Arizona government for the past 20 years or so and we've asked him to share with us some of the on the ground challenges that he faces in administering the program in Arizona and those facing some of his colleagues in Medicaid agencies around the country. Tom? Thanks for coming away from sunshine to what we have here.

THOMAS BETLACH: Yes, I did tell you that I appreciate the opportunity to be here today, and it's a pleasure, but if you had told me I was leaving 80 degrees for snowy Washington, DC, I might have thought twice about it. But I guess you never know in March. It is an exciting and exhilarating but exhausting time in Medicaid nationally. I like to refer to this as the Jurassic Park period of Medicaid. And for those of you that have seen the movie or hopefully read the book, because as in most things the book is much better than the movie, it talks a lot about chaos theory and the fact that you can do everything you can to try and plan complex systems. But at the end of the day, you're going to run up against variables that were unplanned for. And at the end of the day, the Velociraptors will get loose and we will all be running to try and exit the island. So you know, in looking back at where we've been and all the implementations associated with the ACA, all the delivery system changes that are going on with Medicaid, navigating all the politics associated with this issue. It has been a time in which states have had to deal with an unprecedented amount of change in the system. And in a lot of instances, this change is for the best in terms of advancing and moving the system forward. So the National Association of Medicaid Directors under the leadership of Matt Salo, who's here. We're certainly happy to have our own organization that's out there advocating on our behalf and talking about the complexities, the challenges and the successes of Medicaid as we are moving forward.

But Medicaid directors identified their top priorities in a recent survey and 77 percent of Medicaid directors identified four or more significant system changes that they are taking on. The top four priorities were payment and delivery system reform, and I'll talk more about that in a little while and give you some of the specifics of how that's playing out on the ground in Arizona. ACA

implementation, and the ACA implementation dealt with a lot more than just the issue of expansion and coverage. It also dealt with changes in your eligibility systems. It dealt with changes in terms of provider registration and so implementing all of the complexities associated with that and continuing to deal with that moving forward. Long term services and supports, dual demonstrations, trying to establish an aligned system for dual eligible members moving forward through alternative platforms as well. And I'll talk more about that in a few minutes. Eligibility enrollment systems. It's interesting to note that the average tenure for a Medicaid director is currently two years and three months. We've had 23 Medicaid directors turn over nationally in the last little over a year. So we're having a hard time keeping our jobs, I guess, in this environment. The median staff is 359 with a range of 46 to 3,348 and the median budget is \$6.1 billion and ranges from \$632 million to \$90 billion.

So Arizona, as you look at one specific state in terms of its Medicaid program, we cover 1.64 million people today. That's a point in time. Over the course of a year, we will have about 2,000,000 unique individuals enrolled in the Medicaid system out of a little over 6,500,000 individuals in the state of Arizona. So we're impacting a wide range of the population, one in four at any point in time, a \$12 billion program and growing. From the state's perspective, we are the second largest portion of the state's general fund. That has grown over time. It has squeezed out other policy priorities and that continues to be a debate at the state level in terms of looking at the sustainability of Medicaid moving forward. We have mandatory managed care in the state of Arizona with the exception of American Indians. There's about 350,000 American Indians in the state of Arizona. About 160,000 are enrolled in the state's Medicaid program and we regularly deal with 22 tribes and having tribal consultations and talking with them. In Arizona, Medicaid covers more than 50 percent of the births, two thirds of the nursing facility days. As you can see here, we're more than almost three quarters funded by the federal government in terms of once we added the expansion. Public private partnership in terms of leveraging private sector health plans and providers. We have over 60,000 independent providers that are out there, hospital systems, home health workers, a whole range of different providers that are partnering with the state's Medicaid program.

When you look at just the last year or so in terms of enrollment, we've dealt with unprecedented growth. And when we restored and expanded coverage in the state of Arizona, starting on January 1st, particularly in the April, May, June time frame, previously the largest month for growth we had ever had was around 33,000 individuals. And you can see that we added over 70,000 individuals in a single month, 40,000 in a couple of other months after that. And you can see the growth plateaued over the last few months. One of the ways that we measure success in terms of managing the overall cost of trend is looking at the capitation payments, or those payments that we make to our contracted health plans. And you can see what Robin was talking about in terms of the impact on the great recession on a state like Arizona, where we lost about a third of our state general fund. Our population in Medicaid grew by about 300,000 over the course of 18 months and the state had to deal with some very difficult decisions financially. And so as part of that equation we had to reduce provider rates during a couple of different times during that period. So you can see in Arizona, as it relates to provider rates going back to 2009, we actually have overall decreases in terms of the reimbursements that we are providing. Now we've had a lot of growth and so payment is being made in terms of sometimes individuals would be in uncompensated care, so we have broader coverage. So that's a positive aspect for providers, but they will tell you that certainly the pressures

of ongoing rate reduction and ongoing no cost increases are starting to impact them. And that's a challenge in terms of dealing with access – two Cs, not 3 – that states are dealing with broadly.

So just a reminder what the sun looks like here in Washington, DC. But when you look at the strategic direction that we've set out for our program, it mirrors a lot of what my peers are looking at moving forward. So bending the cost curve while improving members' health outcomes, looking at value based purchasing, looking at ways to change the delivery system, whether it's leveraging managed care, whether it's redesigning your fee for service system to involve more care management, more care coordination. Pursue continuous quality improvement, whether it's through performance improvement plans, looking at expanding new use of HEDIS measures, looking at creating new overall quality measures that you're tracking and holding either health plans accountable to or providers accountable to. Reducing fragmentation, and I'll talk more about that in a minute or so. And then maintaining core organizational capacity. So it takes staff to manage all of this and all of the change that's going on in Medicaid. We've got a third less staff today in Arizona and it's always a challenge, not only at the Medicaid director level, but to maintain staff that are able to help move the system forward when they oftentimes have the ability to leave and go out into the private sector and receive compensation that is much higher than what state government can offer.

So in Arizona, our focus around value based purchasing is working through the managed care organizations that we contract with. It's instituting requirements as part of that contract to say we want to ensure that you are contracting for value and we want to have those type of structures put in place. And we want to see you driving the membership towards that value. So we have a requirement in place right now that ten percent of their contracted spend be in a value-based arrangement, and we are increasing that to 50 percent over the next couple of years. And we'll be tracking that and monitoring it in terms of the impact to the delivery system. We are also in the interest of time dealing with issues like federally qualified health centers and the PPS structure, which is a payment system that's mandated by the federal government to provide a cost based reimbursement system. And we're mandating that the health plans pay for that on the front end rather than having the state send a significant portion of that on the back end in terms of supplemental payment. We've got value based plan payment that's tied to quality so we've taken one percent of capitation and one percent doesn't sound like a lot, but when you have a \$12 billion program, one percent adds up pretty quickly. And we've put that into a competitive pool and we've said we've identified six measures, plans, that we want to see you compete for. And those are a combination of access measures as well as ED utilization readmission. Measures that we're using as part of that pool.

And the other thing that we're doing is trying to create a learning culture around this value based purchasing. So we have staff that is dedicated to this. We've created an avenue by which we are sharing information on a regular basis with the plan. So it's just trying to – this is a very difficult thing to do in terms of coming up with new payment structures that replace the antiquated fee for service system in place. Robin mentioned earlier trying to effectively use home and community based services as a way to improve members that are at risk of institutionalization in terms of keeping them in the community. In Arizona, we've moved from almost 100 percent of the individuals in our long-term care program in a nursing facility to today, we are 75 percent of those individuals are in the community. And when you include our entire at risk population, we're at 85

percent. It's better for the member. It's better for the overall finances of the program. And then when we talk about delivery system initiatives, for us it is really dealing with the fragmentation that exists within the healthcare system. So in Arizona, we had a system in which we carved out behavior health services for members with serious mental illness, of which about half are dual eligible, meaning they're eligible for both Medicare and Medicaid. So you had individuals that are living with serious mental illness that oftentimes just have a struggle getting through the day and we had their care being delivered through a system in which potentially four different organizations were involved in their care. And we've changed that so that we have a single plan that's responsible for all the services for individuals with serious mental illness. One other example – I've got a whole list here, but a couple to touch on. Dual eligible members, we've leveraged dual special needs plans so it's important to see that continued in legislation in terms of reauthorization as a platform to provide for a fully aligned and integrated model for the 130,000 members. And there's a number of states that are looking to leverage the D-SNP model moving forward to try and create a better structure for dual eligible members. So that's been a success for us where we've got 40 plus percent of our membership.

And then a final area is just the opportunities that exist with regards to moving data forward. Health information technology and leveraging the fact that a significant amount of money has been invested by the federal government, as it relates to electronic health records and trying to bring healthcare into the 21st century in terms of leveraging technology for all improved member outcomes. And so I'd like to talk about more but I will pass it on.

ED HOWARD: Thanks very much Tom. Interesting stuff and we're going to turn now to Anne Schwartz. Anne is the Executive Director of the relatively new Medicaid and CHIP Payment and Access Commission (MACPAC). The non-partisan Congressional support agency that's advising Congress on key issues affecting both the Medicaid and the CHIP program. Anne has a distinguished health policy analysis background. She served both in the legislative and executive branches. She's been in the private sector and in those senior positions has been exemplary. And today we've asked Anne to spend most of her time focusing on the CHIP program, given the emphasis that some of the other panelists have had more directly on Medicaid. And the likelihood that Congress is going to be considering some action, anyway, on CHIP fairly soon. Anne, thank you for being with us.

ANNE SCHWARTZ: Thanks, Ed, and thank you Barbara, as well. As Ed said, I am with MACPAC. We're a non-partisan legislative branch agency. I'm the Executive Director of the Staff but the Commission itself are 17 experts who interact with the Medicaid program in different ways. We are required to submit two reports per year to Congress, a March report, which just came out last week, and a June report. We have our public meetings here in Washington, DC. The next one is coming up next Tuesday and you can attend these or you can download the presentations and transcripts from our website. Also we have lots of publications and data. We have a whole section of our website called MACStats. Lots of state focused data, which I know is very helpful when your boss comes and says hey what's the whatever in my state. It's all there for you. We do cover a lot more than CHIP. These are the topics in our statute, which is conveniently the first section in Title XIX, the Medicaid part of the Social Security Act. Payment, for example, in our March report, there's analysis that the primary care payment bump, which was a provision of the Affordable Care Act, increasing Medicaid rates for primary care services provided by primary care physicians to

Medicaid levels for two years. We also look extensively at Medicaid's interaction with the health system, the exchanges increasingly and also with Medicare. And in that report there's also a chapter looking at how Medicaid fills in for Medicare for low-income Medicare beneficiaries, particularly in paying for their premiums and cost sharing.

So what is CHIP? It's a program designed to buy insurance coverage for children with incomes that are too high to qualify for Medicaid. Enacted in 1997, and since that time, the number of uninsured children in the U.S. has dropped by about half. It's a much smaller program than the Medicaid, 8.1 million of last year's data, compared to, I think Robin said, 33 million children in Medicaid. And it's mostly children, a handful of pregnant women. Also spending wise, you can see considerably smaller at \$13 billion compared to more than \$400 billion for Medicaid. Its design is similarly shared between the federal government and the states. And it can be operated as a Medicaid expansion or as a separate program. Basically the states could have chosen to simply enroll kids into Medicaid and use the CHIP dollars to cover their care. And for those states and for those children, from the children's perspective, the families' perspective, they often don't know that they're enrolled in CHIP. They're enrolled in Medicaid for all intents and purposes. The separate CHIP programs are often branded separately. In Alabama, it's called ALL Kids. In Georgia, it's called PeachCare. And I'll talk about that a little bit more in a moment. I also want to emphasize that Medicaid Expansion CHIP has nothing to do with the expansion to the new adult group. We used this expansion to talk about two very separate populations.

So how does CHIP differ from Medicaid? From the perspective of the enrollee, it's really important to realize that CHIP is not an entitlement to individuals and states can establish waiting periods for coverage and waiting lists. The income eligibility is higher because it's designed to provide coverage for the kids who are too – incomes are too high to qualify for Medicaid. And that upper income limit ranges, as you see on the slide here, there's a fact sheet from MACPAC in your packet on green paper. And you'll find there the income eligibility level for your state. The income eligibility level often varies by the age of the child and you'll see each of those spelled out in the table there. It is intended to be modeled on private insurance. There's more provision for having a monthly premium in the CHIP program, although the premiums are nominal compared to the kinds of premiums people have to pay in exchange coverage or in an employer sponsored coverage. The benefits can be pegged to a commercial benchmark, although some states peg their benefits to the Medicaid package. And again, the branding to give a sense that it is more like a private insurance project than a government program. From the perspective of the state, there are also some important differences from Medicaid. And the first and foremost is that the funding is capped and the allotments to the state are set in statute. The matching rate is higher, 65 to 82 percent, and again on that green sheet in your packet, you will find the matching rate for your state. And again, states can choose the design, although many states have actually chosen both designs with some kids in a Medicaid expansion design and others in separate CHIP.

So CHIP has been in all the newsletters lately. It's not yet on the front page of the Washington Post, but the debate on CHIP is quite active. Congress last considered it as part of the ACA. But when you look at the ACA, there's some really mixed messages about CHIP that I think are going to be settled relatively soon. First of all, the ACA extended CHIP funding through this fiscal year, although the program itself needs no reauthorization. The program will stay in place, but it's the money that's at issue. It also created a maintenance of effort requirement through fiscal year 2019,

meaning that states can't cut back on eligibility as long as they have federal funds. And it also increased the CHIP matching rate by 23 percentage points. And I want to point out here, it's percentage points, not percent. So it's quite a serious increase in the CHIP matching rate for fiscal years 2016 through 2019. So what you see is there's no funding after 2015 but a higher matching rate. So that's where the debate is engaged right now.

So what are the implications for states? There are no CHIP allotments after this year but states do have two years to use the funds so in MACPAC's analysis, nearly all states are expected to begin the next fiscal year with some funding, although 11 states will run out of funds by December 31st of this year, which is just the first quarter of the fiscal year. The increased matching rate and a capped allotment means that states will spend their funds faster. So imagine dipping into your wallet to pay for your lunch every day and if you take out ten bucks instead of eight bucks, the amount of cash in your wallet goes down a lot faster. And when the CHIP funds are exhausted, the states that are using the Medicaid expansion approach have to continue eligibility for those kids, but they'll be paying out of regular Medicaid match, which as I mentioned earlier, is lower than the enhanced CHIP match. So it means at higher state cost. And for those states, there will be budget issues that they will have to account for. How do you serve the same amount of kids on a smaller pot of money? You can't reduce eligibility levels so other tough decisions will be there for the states. The separate CHIP programs can be closed down because those states have no obligation to continue serving those kids when there are no federal funds available and there are requirements about the length of time they need to notify families. For kids, the kids with the Medicaid Expansion CHIP remain covered. The kids in separate CHIP, 3.7 million, will need a new source of coverage. In that group, they're either eligible for exchange coverage or employer sponsored insurance but 1.1 million of those in MACPAC's analysis are projected to be uninsured because the cost of premiums for that coverage, whether it's an exchange or from the employer, are too high for the family. And the kids that do get covered will experience a higher cost sharing at the service level and in terms of premiums. And they also will see slimmer benefits, particularly dental.

So the choices that are being talked about right now for Congress is whether or not to extend funding and the debate seems to be engaged around whether that's a two or a four year extension. There's also conversation about when you start talking about a program, it's an opportunity to change other aspects of the program. And some of the ideas being talked about are changing eligibility levels, changing the enrollment procedures, changing the matching rate. Should there be incentives to states for enrolling kids. And from MACPAC's perspective, there's been an issue also of trying to think long term. Now that we have the exchanges that provide subsidies for families that are in the CHIP income range, how do all of these sources of coverage come together? We have parents in the exchange, parents in employer sponsored coverage, kids covered in CHIP, another covered in Medicaid. It seems like it's an opportunity now to think about what's the best vision in the long term for kids.

So I'll stop there. You can go to our website. Our fact sheet is up. A letter we sent on extension of CHIP funding is up. And our recent report, which had four chapters on what happens in the event that the CHIP program comes to an end. So you can feast your eyes on all that.

ED HOWARD: Great. Thanks, Anne. The final panelist today, Vikki Wachino, who is the Acting Director of the Center for Medicaid and CHIP Services at CMS. She is now the top federal official

overseeing this vast Medicaid program. She had previously overseen the CHIP program and worked with states on delivery system reform, implementing various pieces of the Affordable Care Act. And today we have asked her to share with us some of the initiatives in the Center to improve not just the care that's delivered through Medicaid and CHIP, but to improve the country's delivery system in general. Vikki, thank you so much. I know it's been a pretty difficult position to walk into and we appreciate your carving out the time to do it for us.

VIKKI WACHINO: Sure, sure, and thank you, first of all, Ed and Barbara, and to the Alliance and Kaiser for assembling this terrific panel. And to those of you – I've been doing Medicaid for a long time, but to those of you who are new to the endeavor, I just have to say, you would have to search far and wide to match the expertise that my three fellow panelists brought to this. So really, I hope you make the most of your lunch and time with them today. What I thought I would do with my time is really expand on some of what Robin, and Tom and Anne have shared with you. And really speak to Barbara's opening point about how the program is evolving and what we're doing at CMS to make the program as strong as possible for the children, adults, pregnant women, seniors and people with disabilities that our program serves.

So I'm going to start. I'm really going to speak to two areas. One is what we're doing to support the types of delivery system reform efforts that Tom described Arizona undertaking. And I'll spend a little bit of time also talking about the importance of kids' coverage to build on some of Anne's points. But I thought I would just start with where we stand on the discussion with states about taking up the Medicaid expansion, since that's a topic of interest in many corridors these days. You saw in Robin's slide that so far 29 states, including the District, have taken up the expansion. The vast majority of those have taken up the expansion as it was written into the law. Arizona was one of those states and we have five states so far that have also taken up the expansion in a way that is a more tailored and state specific and targeted to meet states' needs under 1115 Waivers. We've seen significant impact in states that have expanded since the ACA first took effect. Our Assistant Secretary for Planning and Evaluation did an analysis earlier this year and you can see across the country the reduction in uncompensated care that has taken place since the major coverage provisions of the ACA took effect, which was in October of 2013. The total reduction in the cost of uncompensated care has been \$5.7 billion. Nearly three quarters of those benefits have accrued to states that have expanded. The state of Kentucky, which expanded the program early recently released a report showing some of the benefits of expansion to that state. And they showed that across Kentucky's economy, 15,000 jobs had been created in a variety of sectors as a result of its moving forward with the Affordable Care Act. So I think those two statistics show very well the benefits of expansion. And I think that over time, more states will see the benefits of moving forward with Medicaid coverage expansion for them, their economies, their providers and their employers in the state as well.

I wanted to speak also, although there is a lot of focus on Medicaid expansion, to Robin's earlier point and I think Tom spoke to it as well, there were also substantial eligibility simplifications in the law that took effect both in states that expanded and states that don't. And Robin's slide graphically depicts so well how far Medicaid has come in making the enrollment process simpler and more consumer friendly for people who enroll. And we are going to release data later today that show that since the start of the first ACA open enrollment period in October 2013, enrollment in Medicaid and

CHIP has increased by 11,000,000 people, really speaking to the success of the efforts that states and CMS have made in making coverage simpler and getting eligible people enrolled in coverage.

At this time of year on the hill, there tends to be a lot of focus on costs and spending and budgets so I whipped out one of my favorite slides that shows exactly what the per enrollee costs in major sources of coverage are. And you can see, although there is a lot of focus on costs in the Medicaid program, when you control for per enrollee costs, you can see that per enrollee spending in Medicaid is lower than it is in private insurance and roughly comparable to what it is in Medicare. That said, there's a lot that we in states are doing to make Medicaid as cost effective a program as possible and at the same time moving forward assertively with efforts to promote quality and value in the Medicaid program. So I wanted to spend some time talking about what some of those are.

Under our current authorities, we've moved forward with 15 states in 24 different ways with Health Homes that better manage care for people with chronic and complex conditions. We've moved forward as well creating delivery system reform incentive programs that promote better care in hospitals and other providers. Not in five states as my slide says, but in eight states. I had to correct that this morning. And also moving forward with shared savings and integrated care models. Also importantly, not in my part of CMS, but in the innovation center, we've moved forward with the duals demonstrations that Tom described earlier, as well as very large multipayor statewide reforms through the state innovation model program. And we now have in more than half of all states and covering 61 percent of the U.S. population, a major efforts under way to improve care delivery in all payors, including Medicaid and we're very excited about those.

We also, though, wanted to make sure that we were doing everything we could in the Center for Medicaid and CHIP Services to move forward in partnership with states to promote better ways of improving delivery systems for our beneficiaries. And so in July, we announced a major initiative, the Innovation Accelerator Program that's designed to work hand in glove with states to address and improve care delivery for our populations. After we announced that initiative, we did a little bit of a listening tour across the country and met with states and stakeholders and providers to try to identify the areas in which we thought these efforts were most needed and would be most productive. Early out of the gate, we announced a focus on improving care delivery for people with substance use disorders and since those listening sessions, we've identified three additional focus areas through IAP focusing on care provided for super utilizers. Tom referred to them as high need, high cost populations and I like that framing of it. Moving forward with efforts to promote community integration in long-term care services and also a strong focus on better integration of physical and behavioral health. Right now we have 25 states who are working with us on improving care delivery for people with substance use disorders and we're looking forward to moving forward with more states on those other three areas.

There is to Anne's point a lot of discussion about the future of CHIP. And what I wanted to focus on really is how far we've come with children's coverage. And you can see that over the past five, six years, we've really made significant progress in making sure that children who are eligible for Medicaid and CHIP coverage enroll. And this is the result of significant efforts to simplify enrollment in the program, promote retention of eligible children at renewal, and outreach to kids who may be eligible for CHIP. So you can see that we are moving the needle to make sure that kids get covered and this is the latest data that the Urban Institute was nice enough to share with us. And

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you can see that we're now over 88 percent of all kids who are eligible for Medicaid and CHIP are enrolled. And so while making sure people enroll in our program is important, I think it's also important to focus on what are the bottom line results of the care we're providing. And if you follow the news and follow the research, the National Bureau of Economic Research released an extensive analysis just a month or so ago that showed for kids who are covered in Medicaid and CHIP, when they go on to be adults, they do better and have higher wages as a result. So they also estimated that as the federal government, we get a return on that investment in kids' coverage in terms of reduced federal spending. And for every dollar that is spent on kids' coverage, the federal government down the road spends 56 cents less than it would have in the absence of our programs. So I think that's a great way of illustrating the impact that public programs have, not just on the populations that they're intended to serve, but on us as the federal partners. And a great illustration of how successful public programs can be generally. And so I will choose that as my ending point for my presentation and yield the rest of my time for questions that I'm sure Ed will field very well.

ED HOWARD: Terrific. Thank you very much, Vikki. And now we do have the opportunity for you to ask the questions. This is a primer. Don't be afraid of asking a very simple question. That's the whole point of this exercise. And as I said before, if you have a complicated question, don't hesitate because we've got the firepower up here to respond to anything that you might come up with.

THOMAS BETLACH: We'll answer we all did the best we could.

ED HOWARD: That's right. Let me just start, if I can, to clarify one thing. Anne, you mentioned the fact that CHIP programs come in a couple of different flavors, either a Medicaid expansion or a separate CHIP program, which is a choice that states have had since the program started. How much of CHIP enrollment is actually in a Medicaid expansion mode as opposed to these separate programs?

ANNE SCHWARTZ: That's a number that I should have at my fingertips, which I don't.

Ed Howard: I only ask because back when we were watching this getting put together in the mid '90s and Senator Rockefeller was a key factor in it, we were informed that the Medicaid expansion aspect of implementing CHIP was a way mostly to get off the ground fast, as opposed to a long term structure. Tom, do you have a sense of that?

THOMAS BETLACH: I will give you an Arizona specific example because we had a CHIP program that was in place. We had a freeze. We put in a CHIP 2.0 program and in terminated on January 1, 2014. We had roughly a little over half of the population that went into the Medicaid expansion and then slightly under half were no longer eligible, and we covered up to 200 percent of the federal poverty limit. That was our experience in Arizona.

ED HOWARD: Okay. And Anne, you were – go ahead.

ANNE SCHWARTZ: I'm just referring to my report here and there's a figure in which we look at the distribution on spending for kids based on whether the state chooses Medicaid expansion and it's not exactly a bell shaped curve but these are states going from zero to ten percent of their money

in Medicaid Expansion CHIP to 90 percent. So it's definitely more than half, just looking at that distribution.

ED HOWARD: And it's important because as you pointed out, and I don't think this has gotten a lot of attention but funding continues beyond the end of fiscal '15 for people enrolled in a Medicaid Expansion CHIP program. Right?

ANNE SCHWARTZ: That's right.

ED HOWARD: Okay. We have a couple of questions. Barbara, you want to go ahead?

BARBARA LYONS: Yeah, we have a question here from a Congressional staffer who is trying to put the dots together from some of the issues that are getting attention in DC. So this question I think we should be able to handle pretty easily. Can you explain the overall impact of a *King v. Burwell* decision on Medicaid Expansion programs currently taking place in states without state run exchanges? In other words, will an elimination of these programs hurt Medicaid beneficiaries in states that run their own exchanges? Anybody?

ROBIN RUDOWITZ: Well the *King v. Burwell* case is really related to the subsidies in the marketplaces and is not directly tied to the Medicaid expansion. So in states that have expanded Medicaid and have a state based exchange and then states that have expanded Medicaid and have a federally facilitated marketplace, the Medicaid expansion piece is not at issue in the case.

ED HOWARD: If you are going to come to a microphone, we would ask you to identify yourself and be as brief as you can in asking questions.

CATHERINE FONTENOT: Hi. My name is Catherine Fontenot and I am a Truman-Albright Fellow with the Department of Health and Human Services. I don't think that Medicaid can be separated from the definition of poverty in the federal poverty level and the definition of low income. So can someone give the group kind of a background definition on what the federal poverty level is and how it's calculated. And when I say that I am talking about the 1960s USDA grocery shopping definition.

ED HOWARD: I'm sure you remember how that was formulated. Any statisticians on our panel?

VIKKI WACHINO: I think it is a statistical question of how the – and probably best directed to someone who works for Commerce or CPS. But it's a good question and I know that there's periodic discussion about what you count and what you don't count and is it an adequate measure.

ED HOWARD: As the senior person on the dais, thank God I'm not on the panel. I will tell you that a woman named Mollie Orshansky at the Census Bureau devised this formula for calculating how much it cost to feed a particular size family at that point in history. And since the average family spent one third of their total income on food, that number was then tripled to get the poverty line for lower income people. And over time, of course, the percentage of food budget has gone down to well below ten percent, if I'm not mistaken. But the actual poverty level has never been adjusted except to account for inflation in the 50 years since. The overall poverty level is what \$11,000 for

an individual. Does that sound right, Robin? And the 138 percent figure that you've heard several of the panelists use is the upper limit to which states must cover under Medicaid for adults who otherwise weren't covered before the Affordable Care Act. And of course, that is true only in the 29 jurisdictions where the expansion has occurred.

CATHERINE FONTENOT: Thank you.

ED HOWARD: Now you know why we have an expert panel.

MICHAEL MASSER: Hi. Is this on? My name is Michael Masser. I'm from Simon and Company [PH]. We're a healthcare consultancy firm and my question has to do with states that expanded through a waiver. A lot of these waivers include additional cost sharing or reduction in benefits and the rationale is that these people have higher incomes, but for benefits like transportation, which are linked to a clinical need, that doesn't really make sense. I wanted to see if I could get your view on states that have expanded through waiver and might expand through waiver in the future.

VIKKI WACHINO: Thanks for the question and the comment. I'll say to my earlier comments that we have with a number of states, five so far, tried to work to tailor state specific approaches and in some cases, we have modified our transportation benefit slightly in those states. We've been very carefully monitoring the impact that that waiver has on access for people who it affects and we'll be looking at it very closely to see the impact going forward.

ED HOWARD: Yes, sir.

HUNTER COOHILL: My name is Hunter Coohill. I'm a law student at American University. I've formerly worked for Colorado State Medicaid and I have a bit of a specific question. It surrounds waiver simplification. I know that as we're moving towards more coordinated care, I just wanted to get your views on what would be a good approach for maybe simplifying the HCBS Waivers. Is that looking at person-centered budgets, so bundled payment systems as opposed to states that have ten – like Colorado, for example, must have ten or 12 so.

ED HOWARD: You might also say what an HCBS Waiver is. This is a primer. Anybody?

THOMAS BETLACH: I'll take the first stab but I'm sure others can jump in and offer. I know several states that have operated under a multitude of different waivers and they've looked to sort of consolidate that approach through something similar to what Arizona did early on, which is have a global 1115 Waiver to try and capture much of that flexibility within a waiver like that, rather than trying to manage multiple different waivers. But I'm sure Vikki has thoughts on it, as well.

VIKKI WACHINO: Sure. I think for a state like Colorado, we can look at a couple of different approaches for simplifying the number if your concern is the number of waivers. There are also a couple of options that are now available in the Home and Community Based Services area that are available under state plan that weren't available before. So when states like yours come to us, we look both at how could we streamline and move things under state plan authority, as well as to Tom's point. In some cases, we worked with states to consolidate those authorities under 1115. The

ability to do that depends on what the requirements of your waivers, your individual waivers are and how well they align with each other.

BARBARA LYONS: And just to add on to the general topic of Home and Community Based Waivers, I mean I think this is one area where the Medicaid program has really made great strides in changing the way services are provided for people with disabilities and seniors who have long-term care needs. Two decades ago, most care was provided in institutions. Beneficiary preferences have changed, the standards have changed, and Medicaid really has been the program out there leading the way on that transformation.

VIKKI WACHINO: So two points building on Barbara's point. One is that we just two years ago finally reached the point in Medicaid where we're spending as much on long term services and supports in the community as we are in institutions. And as you saw from Tom's graph, Arizona reached that point even earlier than the rest of the country. Also, one of the most significant bodies of work we have underway at CMCS now is implementation of new regulations released a year ago moving towards home and community based settings over the next five years. So that it's another big step forward in our efforts to promote community integration.

ED HOWARD: And can I just ask, Vikki, if you could sort of back up a step – the reference to waivers. What is it that is being waived and is that the only way that you can, if you're a state official, accomplish something that doesn't look quite normal in a Medicaid program?

VIKKI WACHINO: Sure. Without turning this into a Waiver 101, there are a couple of different authorities in the Medicaid program. What the questioner was asking about refers to targeted home and community based waivers that allow states with our approval to extend long term care, home and community based care, to certain sets of people and certain sets of services. There are also authorities outside of the waiver process through the state plan process, which is how we do most of our business that allows states to achieve very similar goals, subject to different requirements. Outside of all of that, there are 1115 Waivers, which are broader authority that states use to depart from the statute in different ways. And states use those for anything from running a managed care program, as Arizona has done since 1982, to extending eligibility to people who wouldn't otherwise qualify for the program, to operating delivery system reform pools.

ED HOWARD: Very good. Yes, ma'am?

CAITLIN CONNOLLY: Thanks very much. This has been really helpful. My name is Caitlin Connolly and I'm with the National Employment Law Project. I just wanted to ask –the information and facts were fantastic when we look at sort of the value that Medicaid provides, especially when you're considering the matching funds. And yet we're seeing so many states that are proposing cuts to their Medicaid budgets – Illinois, Ohio, even Connecticut are proposing cuts that would also increase the eligibility threshold. And I'm wondering, some of the data that's been presented, especially around CHIP, shows that that's not the wisest investment or way to cut because the return on investment is so much greater. And I'm just wondering if there is some extended data that shows cutting Medicaid actually is more costly. Or another way of saying that, investing in Medicaid can save the state dollars.

THOMAS BETLACH: Well I'm going to take a first cut at this but I'm going to do it more from my history as a budget director from the State of Arizona before I went into the Medicaid program. And that is the hard fact that states have to balance their budget each year and when you look at a state like Arizona, who has invested heavily into its Medicaid system, receives a very significant federal match as part of that. But at the same point in time, has probably some of the highest higher education tuition increases in the country as well. From the state's perspective in looking at what amount of money it has to invest in Medicaid versus other policy priorities, that's really where states are struggling in terms of balancing the ongoing costs. Even though there's significant investments being made through the ACA in terms of higher matches, there's still match for the base population that has grown. There's still match required to fund the increased costs. So I really appreciated the information that Vikki was sharing in terms of some of the longer-term impacts and positive benefits and the value of Medicaid associated with the coverage of children, but to some extent, again from my history and in talking with my peers, some of it is just the reality of having to balance a budget at the state level in terms of having to make these very difficult decisions. And we've had to make very difficult decisions along the way.

ROBIN RUDOWITZ: I would also just echo some of that in that when a state, it is difficult for states to cut back on their Medicaid spending because of the match. They need to make larger program cuts because to save some state dollars, they need to cut more than just the state dollars, because they also would be losing the federal dollars. But as Tom said, states are balancing their budget every year and making difficult decisions. These decisions, I think, are very acute during economic downturns when the needs for the program and demands for the program rise. At the same time, state revenues are declining so they have even less money to support the program so there's a real crunch for states during economic downturns. And that's when states are typically making a lot of cuts. As the economy has started to recover, I think it's given states a little bit more time to both reinvest in some of the cuts that were made as well as look to these delivery system reforms and payment reforms that might not have immediate budget savings but are things that would affect both care and cost over time.

ED HOWARD: Barbara, go ahead.

BARBARA LYONS: And just to add on to what Robin said, I think – and we work with Tom and NAMD every year to do a state budget survey to find out what the issues that states are facing and how they're meeting their budgets. And over the years, we've seen that states generally have tried to protect eligibility as much as they can and tried to squeeze savings from other parts of the delivery system in order to maintain that coverage for people. Because for most of the populations covered by Medicaid, if they don't have that coverage, it's not like they have something else they can go to. They either can't afford private coverage or they have these extensive needs for long-term services and supports that aren't covered by private insurers.

ED HOWARD: Can I just go to the premise of the question? To what extent are states cutting back on Medicaid expenditures now as the economies are improving? Is the 2008, 2011 situation as depicted in some of the slides that we've seen, really persisting or are we seeing a little loosening?

THOMAS BETLACH: I think when you go back and look at the Kaiser and NAMD survey, there were a lot fewer cuts being made. Really as a Medicaid agency, you only have a few levers by

which to make reductions. It's provider rates and there were not a lot of provider rate reductions in the last survey. You can change benefits and that depends upon what type of benefits that you have that are optional benefits. And then you can look at changing eligibility. And for most states that becomes very difficult given the constraints that are put on at the federal levels. So those are really the limited levers that you have to generate real money in a short-term basis. But again, I think if you look at the survey, there were not a lot of significant reductions and nearly not to the extent that there were during the Great Recession, 2008, 2009, 2010 and, and 2011 a little bit.

VIKKI WACHINO: I think also what you see in Robin's data is that states are moving towards delivery system reform. Because ultimately, although it would be a challenge for Tom in his old job as Budget Director where you have to get up front savings, the real solution here is moving towards being a more effective payor and making the dollars you're spending go the furthest for the population you're serving. And that's why I think initiatives like the State Innovation Model and the Innovation Accelerator Program are important because they're designed to promote more cost effective care in areas like long term services and supports, where the amount of federal and state investment is not small.

THOMAS BETLACH: And that's really what's exciting about this time period, is when you look at all the different changes that are occurring nationally within. And that's one of the unique aspects about Medicaid is you have states that are being innovators that are focusing on how their delivery system is arranged locally and having the tools by which to make some of those changes and address that through the Medicaid system, which is a significant purchaser in states.

ED HOWARD: Yes, ma'am.

DANIELLE MOST: Hi. My name is Danielle Most and I'm with Congresswoman Elizabeth Esty's office. I have two questions. First, do you know if the new SGR legislation, which affects Medicare funding reimbursements, at all affects Medicaid funding? And second, I've been hearing from a lot of people in our state and our district that primary care providers and specialists aren't accepting Medicaid patients. And is there anything being done to address that problem?

ANNE SCHWARTZ: Well I'll start and maybe others can chime in. Medicare payments to physicians are set by CMS by the federal government. Medicaid payments to physicians are either set by the states or are set by the managed care plans that contract with the states. With the exception of the primary care bump that I mentioned, there are no Medicaid payments that are set at the federal level. There are other provisions that may go in that bill that would affect the Medicaid program, but that wouldn't affect payment to physicians and other providers. On the participation rate, that has been sort of a perennial issue in the Medicaid program and in part, that's what that provision of the Affordable Care Act was designed to address because the research literature does show us that higher fees are associated with greater physician participation and therefore greater access. It's not the only thing that affects physician participation. Issues around paperwork, issues around compliance, no show rates also affect physicians' willingness to participate in the Medicaid program. You also see much higher participation among general pediatricians than among other physicians in other specialties. Obviously, there are a large number of kids in Medicaid and so I think there are differences in terms of kind of the service model of different kind of physicians that

would affect that as well. But states have done a lot of experimenting in this area to try and ensure that they have adequate access for their enrollees.

THOMAS BETLACH: The only thing I'd add, and it doesn't tie to the SGR bill, is that the federal government did create a cost based reimbursement system for FQHCs and in a state like Arizona, FQHCs represent about 25 percent of the primary care network. And so that is an issue of concern for states as it relates to just the cost. And on my slide I had the percent increase in FQHC payments going back to '09. It's been about 35 percent. That's largely outside of our control but that is federally mandated. The only other things on the SGR bill that I would mention is many states are out there trying to work with the dual special needs plans as a platform to create an aligned integrated delivery system for dual eligible members. And the continuation of that authority is contained within the SGR bill. So we'd like to see that extended for a significant period of time and NAMD did a letter making some recommendations about improvements that we see that could get done through the D-SNP structure.

ED HOWARD: Anne?

ANNE SCHWARTZ: Yeah, I will say, at Vikki and Ed's suggestion too, that the continuing extension of CHIP funding is being talked about now in conjunction with the SGR bill, which obviously the SGR bill, something has to happen by March 31st or you will see some pretty extreme cuts in Medicare physician payment. And because that's a must pass vehicle, those concerned about the CHIP program are looking at that as an opportunity. There's ten more days until that happens and we'll see if that happens. And if not CHIP could be considered at a later date.

ED HOWARD: Maybe before September 30th.

ANNE SCHWARTZ: We'll hope.

ED HOWARD: Not that much later. We have about ten minutes left and I want to make sure that we get in as many questions both on the cards and on the microphones as we can. And I would ask you while we go through these last ten minutes, if you would pull out the blue evaluation form and fill it out as you listen. That would be greatly appreciated. Yes, ma'am.

LIBBY NEALIS: Yes, thank you. I'm Libby Nealis with the School Social Work Association. My question is regarding school based Medicaid services and reimbursement. Given that the bulk of enrollees are children and yet the small percentage of expenditures that actually go to serving children, it would seem that you would maybe want to take advantage of the schools as a place of Medicaid eligible services. Medicaid eligible providers like social workers providing these services. And yet it's really a big challenge for the schools and most don't undertake even trying to pursue Medicaid reimbursement. I'm just wondering if there's states that are looking at trying to provide guidance to schools in doing this. It would seem it was to their benefit to draw down more of those dollars. I know I don't think CMS has offered guidance to schools and it's been a challenge for us for years trying to reach those kids, especially given that so many outside providers are not accepting Medicaid.

THOMAS BETLACH: So I'll give you state perspective on that and we work consistently with our school districts and our schools. But clearly the challenge there is that schools are not structured to be medical providers from the sense of the billing aspects of it. So when HHS OIG came in, we had a larger settlement on that topic than any other topic since I have been in the Medicaid organization. In fact, the findings from that audit exceeded all the other audits, and we get audited like several times a month it seems, put together. And so I just think the complexities of having to meet the expectations of the healthcare system and what's involved in a claim and tracking all of that for a school system that already has a lot of reporting requirements. Adding that on top of it has been something that has just been very difficult to overcome and meet the expectations of the auditors moving forward. So we've had to really tighten our program around school based claiming. That's just been the realities of what we've had to go through and I don't know an easy way around that.

VIKKI WACHINO: We did late last year release guidance in the form of a letter to state health officials that was designed to remove some of the biggest barriers to school claiming. And that's on our website at Medicaid.gov. And if you need someone to walk you through what that allows and what was the objectives behind it, come up to me afterwards and I'll put you in touch with one of our team.

LIBBY NEALIS: Thank you.

ED HOWARD: Barbara, do you want to go ahead?

BARBARA LYONS: We have a question for Tom. So how is your Medicaid agency working with the health system stakeholders to use the various federal grants in a coordinated way to meet your state's health priorities?

THOMAS BETLACH: We have endless conversations with all of our stakeholders in terms of pulling them together on a very regular basis. So we have all of our provider associations. We have a number of advocacy groups. We have a number of public forums in which we try to engage folks. So we went through the State Innovation Model. That requires a robust stakeholder process. We go through our 1115 Waiver process on a regular basis. That engages the community. We, with the 22 tribes, have conducted over 60 tribal consultations since I've been director. So that's an ongoing process. So there's a number of different forums in which we're engaging all the different folks that we touch on a regular basis to look at the opportunities of either additional federal programs or just meeting the day-to-day needs of the Medicaid system and trying to move it forward.

BARBARA LYONS: Maybe this is a good one that we're getting near the close but it's for Vikki. In your new leadership role, what are a few of your top priorities that you see going forward over the next year?

VIKKI WACHINO: Well that's a softball, which I appreciate. Thank you whoever asked me that. I mean, clearly getting the Innovation Accelerator Program fully working for states and moving forward quickly with delivery system reforms for the Medicaid population is at the top of my list. We're also spending a lot of time thinking about the best ways to strengthen our managed care policies and are spending a lot of time on that, including developing proposed new regulations. And the last area I'll just call – because one I mentioned earlier, which is implementation of our home

and community based roles around making sure that people are being served in the most integrated setting possible.

ED HOWARD: Nicely done. That should keep you busy at least until Memorial Day. Well, we've exhausted our time but not our energy to deal with this program. I actually have learned a great deal about the Medicaid program. I thought I knew a lot. And I want to thank you for some insightful questions, thank our colleagues at Kaiser for their contributions, both to this sponsorship and to the shape and content of the discussion today. And ask you to join me in thanking the panel for coming up with great answers to a whole variety of tough questions. And we'll see you next Friday for Medicare.