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Medicaid at 50
A Look Back-And Ahead
Kaiser Family Foundation
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DIANE ROWLAND: Good afternoon and welcome to the Barbara Jordan Conference Center, named for our former trustee, Barbara Jordan, the U.S. Representative from Texas who would be so pleased to know that we're here to look at a piece of legislation that another Texan put forward and that that program has continued to be so central to health coverage for America's poor and disadvantaged.

I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation, and I also serve as the Executive Director of our Kaiser Commission on Medicaid and the Uninsured. So I'm pleased that you could join us for this forum reflecting on Medicaid 50 years after enactment. It provides us with an opportunity to look back at the evolution of this key component of our nation's health coverage for low-income people and the role it plays today in our health care system for over 70 million Americans, and at the opportunities, challenges and likely changes we will see in the next chapter of Medicaid's story.

The Kaiser Family Foundation established our Commission on Medicaid and the Uninsured – at first naming it the Commission on the Future of Medicaid, which got changed to the Uninsured when we weren't quite sure what Medicaid's future would be, in 1991 – to serve as a policy institute for

providing information and analysis on health coverage and on access to care for the low-income population, with a special focus on Medicaid's role because Medicaid was so central to all of the services that many in the low-income population needed. The Commission's work is carried out by Kaiser staff under the umbrella of a bipartisan advisory group of national leaders in health and public policy, chaired by Jim Tallon, who unfortunately could not be with us today. But many of our Commission members are, and they're going to share some of their perspectives with us, along with the other panelists.

Throughout the last nearly 25 years, half of Medicaid's life, we at Kaiser have studied, analyzed and helped inform policy debates about Medicaid's future and coverage of the low-income population. Today, we release a new Kaiser Commission Report with the innovative title, Medicaid at 50, that draws on the many years of research and analysis that we have conducted, as well as others, looking at Medicaid's role at the federal and state level and its coverage of low-income Americans. I would like to really acknowledge the outstanding effort in this report by Julia Paradise, the Associate Director of our Kaiser Commission, in putting together this comprehensive march through Medicaid's past, and together with my colleague since the launch of the Commission in 1991, Barbara Lyons, who directs the Commission's work, in preparing this forum and the

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many products of it. We will draw today on key findings of this report and, with our panelists, both look back and look forward to assess what we've learned and how that can inform the future.

So to set the context for our discussions, let us begin with a brief overview and the year is 1965. And I'm pleased to look out in this room and see that there are at least some people who were born before 1965, since at many of these briefings we always wonder. 1965 was a very busy legislative year and you have before you the redline, which is the enactment of the Social Security Amendments of 1965, which brought us both Medicare and Medicaid. But since they're kind of hard to read, let me tell you, that it shows that on July 29th Congress sent these amendments to the White House and on July 30th of that year, President LBJ, Lyndon Baines Johnson, signed the legislation in Independence, Missouri. What you might note, though, is that it's Public Law 8997, which means that it's the 97th piece of legislation signed into law since January of that year. So when we look at this year and the 50th anniversary, there's a lot of them, including Community Health Centers, Medicare and now, today, we talk about Medicaid.

But what you see in the Act is that this was an Act to provide hospital care, of course, for the Medicare population,

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but also to improve the federal-state public assistance programs, i.e., Medicaid. And what you also see in the bottom signature period is that it was signed into law – I think this is very nice – it was signed into law in Independence, Missouri, on July 30, 1965 by Lyndon Baines Johnson, but it was signed at 5:19 Washington time. But you also see that the very end of the legislation, where the signatures are, is part of Title 19, and it includes provisions related to paying for Medicaid services and uses the famous words "FMAP" for the financing, so the Medicaid legislation and its role as financing health care is there at the very end on the signature page.

But when we think of the origins of Medicaid, we really think of a program that really was building on the public assistance model, fundamentally different than what was envisioned in the legislation that created the Medicare program. It was intended to be a means-tested program, focused on those eligible for public assistance through the Aid to Families with Dependent Children Program or through the Aged, Blind and Disabled Cash Assistance Program. But it was also structured to be an entitlement to states because states were entitled to federal matching funds to match their services to any of the individuals who were eligible for coverage under the programs that were being covered by the states.

It also set up, as a core, a number of requirements that the federal government said, if you do these things, we will match those funds, and a number of options for the states to undertake and still receive federal matching funds. But in that partnership, it was the states that were to administer the program and to design their program for specific state needs within the federal guidelines. And this framework, while a little bit removed today from the welfare system, is still the basic framework of the Medicaid compact between the federal government and the states.

But this program has clearly evolved over time to meet the changing needs of society. Enacted in 1965, the first major expansion came in 1972 with the federalization of the Cash Assistance for the Aged, Blind and Disabled through the Supplemental Security Income program. We then looked at the Medicaid program's increasing role in long-term care and long-term care services. Later on, home and community-based services waivers were allowed in order to give states the option of helping to rebalance their long-term care spending from nursing homes into the community. For children with very high special needs, the Katie Beckett option became available and then, over the '80s, Medicaid was extended for women who were pregnant and especially for low-income children over and over until by the end, all children under poverty and very

young children under 133 percent of poverty were to be covered in all states as a national standard for Medicaid's coverage of children.

In addition, by 1997, there was more attention given to coverage of children with the enactment of the State Children's Health Insurance Program, which really for the first time totally helped to sever the relationship between welfare and cash assistance and Medicaid eligibility. We also saw during the period of the '90s much more innovative use of the 1115 waiver authority in the Social Security Act to expand Medicaid eligibility, culminating, of course, in the enactment in 2010 of the Affordable Care Act, with its many provisions that included the new minimum income standard for all adults as well as continued coverage for children, that we know the Supreme Court threw a few wrinkles into that evolution and now we see the continued implementation of the Affordable Care Act, with some states expanding and others continuing to debate and review their options for the future.

But Medicaid has never been a uniform program throughout its history. The framework did give states a lot of choices about how to structure their program, especially choices around benefits, around payments, around delivery of services and organization of care. And so we see that with this common framework there continues to be substantial

variation across the country and the scope of Medicaid's coverage of the non-elderly population and in many other services. As researchers and analysts, it gives us a very interesting framework to try and analyze, to try and figure out what's going on in each of the states, what kind of data we can get available, and also raises constantly the question of what should be national so that anyone in any state should get it in return for the federal dollars on the table, and what should be left to the states – an age-old debate that continues to this day in the Medicaid program.

So in sum, I think as we move forward, what we want you to remember is that this program has become something much bigger than its original role was and has now a very central part in our health care system, providing coverage to over 70 million Americans, including 33 million American children. Providing some assistance that I like to say makes Medicare work for 20-percent of the Medicare population who have dual eligibility and need many services that are not covered by the Medicare program, including, of course, long-term care services. And in long-term care, Medicaid today helps some 1.5 million people who are in institutions, and another 3 million receiving community-based care, so remains our only source of real assistance for people with ongoing long-term care service needs.

And finally, at 16-percent of our national health expenditures, over half of our expenditures for long-term care, so that it is always going to be on the forefront of debates over payment, over costs and over the share, then, of the federal versus the state budget going to this program, and in the states, it's a major source of federal assistance so that it enables them to get federal dollars to help support their coverage, but it also requires state matching funds and has, over time, been, of course, a problem in terms of recessionary times when the federal government needs to help boost some of its expenditures to help keep the states able to meet the counter-cyclical pressures. So, as we move forward, we've got a program now that is a central component of our health care system that is providing vital services to millions of Americans and that we need to look at as a foundation for going forward in the future. But before we focus on that, I'm going to turn to my colleague, Barbara Lyons, to give us a perspective from the beneficiaries of the program before we get on with our panels.

BARBARA LYONS: Thank you, Diane. And it's a real pleasure to be here today and to see so many of you participating with us in this conversation about Medicaid at 50. As you saw in Diane's presentation and in the report that's in your briefing folder that we're so happy to have

done, we do a lot of work on the Commission in terms of pulling together facts, information and analysis. In fact, I think we're pretty well-known for doing that kind of activity. But I think an additional defining feature of our work is that we do have a focus on the impact of programs and policy changes on people, and trying to help policymakers understand how changes are playing out on the ground.

We do, in our work, quantitative analysis where we're trying to generate numbers to define the scope of policy issues related to coverage, access and financing. But we also do qualitative work through focus groups and interviews with individuals to get underneath those numbers and provide some context on the role of the Medicaid program for the various groups of people that it serves.

In light of the 50th anniversary and in light of the major changes that are underway with regard to Medicaid at the state level and at the federal level, we have updated our work that we refer to as the Faces of Medicaid, where we try to bring individuals voices to the forefront. We put together a set of eight video snapshots that are illustrative of the various roles that Diane identified in her slides. And as Diane noted, many of you in the room have been working on these issues for a long time and are very familiar with these roles. But there is a whole new generation of folks working on policy

issues that may not be as familiar with all the various roles and types of activities that Medicaid is involved with. And so, I hope these videos will help inform people new to the program.

While we don't have time today to view them all, I'm going to do a short video introduction to five of the folks that we have interviewed and then play two individual profiles today. The rest will be available on our website -- actually, I think they're available now. So, before we roll that, I want to thank, gratefully, the individuals who generously shared their stories with us and took quite a bit of time to do it. We're really, really appreciative to those folks. I want to do a big shout-out to Mad Squid Media. Miriam Weintraub and Jennifer Oko in particular for helping us with the production aspects of this and then on our staff, Melissa Majerol really conceived, developed and carried this effort forward so that we would have these Faces to share today. Along with Francis Ying on our staff who has the technical skills to bring it together. We really appreciate all of that.

So, let me go ahead and direct your attention to the screen, and we can roll the video and dim the lights. Thank you.

[START VIDEO—FACES OF MEDICAID]

TODD: To me having Medicaid for my daughter Jane means health and security for her future.

PAMELA: Medicaid means peace.

ROBIN: Medicaid changes our life--for the better.

PENNY: It also impacted my ability have a new life.

ROBIN: I am Robin.

TODD: I am Todd.

PENNY: My name is Penny.

WENDY: My name is Wendy.

MARIA: I'm Maria, and my children are covered by Medicaid.

TODD: My name is Todd. I live in Orem, Utah. We first learned about Medicaid when my wife got pregnant. And has covered her during that time, my wife, and is now covering my little daughter. I'm a full-time student at the University of Utah. One my part-time jobs is working as a graduate assistant. My other part-time job is my internship, and it's working with Deseret Industries as a development counselor.

Jane brings so much into our life. Being a parent was nothing like we expected. Every day is different and so she keeps it real. It's fun.

When we found out that my wife and Jane would be covered, it definitely felt like a burden lifted, a weight off of our shoulders.

ERIN: The ability to have Medicaid while I was pregnant meant that I didn't have to worry. There was one time that I had to go to the ER. I was able to find comfort in being taken care of through Medicaid.

TODD: So after she was born, we were able to know that she still would be covered. Vaccinations, her regular checkups, anything on the health care side, she has covered by Medicaid.

Not being insured and not having my wife insured is one of the scariest things ever because what—if something happens? I can't get really sick or injured. I have to work, I have to provide, I have to finish school. It's very unnerving not knowing what to do and just kind of being, like, I guess we have to suck it up, you know, until we can have a doctor someday that we can just go into for a checkup. Like, we don’t have that. So, it's very scary.

We make just enough to not qualify for all the other programs, but we don’t make enough to really take care of ourselves the way we would like to, if that makes sense. You know, I used to think people who accessed welfare, health care type assistance from the government were just lazy people who couldn't take care of themselves. And I've never not had a job. I've always worked very hard. I've been in school. But I've never been able to take care of myself the way I'd like

to, and so now I have kind of an understanding for why these programs exist and how much they can benefit people who are hardworking Americans, who just aren't at the place yet, where they can afford private health insurance or in this situation, here in this state that I live in, access it through the Affordable Care Act.

I'm Todd. This is my daughter, Jane, and she's covered by Medicaid.

PAMELA: Abdul is a 25 year old man. He has developmental disabilities. The primary one is apraxia, but he also has some intellectual disabilities and learning disabilities. Apraxia is sort of similar to when someone has a stroke. Primarily it has impacted his speech. But he still has problems with fine motor skills.

Abdul, for say, three years, kept looking for a job until he found this program called Project Search. It's a Medicaid Waiver program, for people who have disabilities. Andthis involves working as an intern for approximately a year, and during that period of time, they had a special educator and a job coach. That job coach helps him to navigate his work environment. Helps him to feel more confident about what he does, and gives him guidance on a regular basis, so he can feel confident in what he's doing at work.

They also did something called travel training, which taught him how to catch the public transportation, to and from work.

ABDUL: It helped me become more independent because I can take the train, the bus, to there, to work.

PAMELA: I think it's really boosted his self-confidence. I can tell he's much more confident than he's ever been. To me and my son, Medicaid means life. Medicaid means a future.

My name is Pam, and my son Abdul is covered by Medicaid.

[END VIDEO—FACES OF MEDICAID]

DIANE ROWLAND: And I'm sure Abdul is really rooting for the Wizards as they go forward. We didn't realize how timely his shirt would be for this event.

I think that these portrayals really do show the scope of the population that Medicaid serves, the range of challenges that we face as we try and make sure that those who are the neediest among us get the services they need. So we're going to turn to this panel, Medicaid's Role for People, Access and the Safety Net to really talk about Medicaid's impact for people across the nation and focus on its role for children and low-income families, the elderly and people with disabilities,

and the uninsured. But to really try to address some key opportunities, challenges and policy debates as we go forward.

We've asked Trish Riley, a member of our Kaiser Commission, the Executive Director of the National Academy of State Health Policy, to serve as our moderator. Trish is a current and former head of the National Academy of State Health Policy and spent many years in health policy and Medicaid positions in her native state of Maine.

We're also going to draw upon Sylvia Drew Ivie, another one of our Kaiser Commission members who is the Mental Health Deputy for the LA County Board of Supervisors and in previous lives served as the former head of the HHS Division of Civil Rights and of the National Health Law Program or NHeLP.

And joining her will be Elizabeth Taylor, the Executive Director currently of the National Health Law Program and a former member of the Department of Justice team.

And finally, Fred Cerise, the CEO of Parkland Health and Hospital System, another member of our Kaiser Commission and the former head of health and hospitals overseeing Medicaid in Louisiana and had the good fortune to be there as the state tried to first reform its health care system and then as it tried to recover from Hurricane Katrina.

To set off our discussion, I'm going to turn to Julia Paradise, the author of Medicaid at 50 and our Associate

Director of the Kaiser Commission, to set a few slides in motion to offer us a few facts to underscore our discussion. Thank you, Julia.

JULIA PARADISE: Thanks, Diane, and good afternoon everyone. As Diane said, I'm going to begin this panel with just a few slides to set the context and to do that I'll be drawing on data and analysis that are really part and parcel of our ongoing work to document key aspects of the Medicaid program and its impact in our health care system. There we go.

Medicaid plays many roles in our system, but its first purpose is to provide health and long-term care coverage for low-income Americans, most of whom would be uninsured or underinsured otherwise. Prior to implementation of the ACA, Medicaid covered half of all non-elderly Americans with income below the poverty level.

The program plays an especially large role for certain populations. It covers more than one in three children and close to half of all births. Medicaid is particularly important for children of color, who are disproportionately likely to be poor, and also for children with special health care needs, for whom commercial insurance is generally inadequate.

Medicaid covers a very large share of children in poor families, and a large but still very much smaller share of

parents in those families, reflecting states mostly much more restrictive eligibility for adults. Equally importantly, although less widely appreciated, Medicaid also provides coverage for one in five Medicare beneficiaries and for millions of children and adults with diverse physical impairments, cognitive disabilities, mental illness, and intellectual and developmental disabilities, as we just saw.

Finally, reflecting its long-term care role -- its major long-term care role -- Medicaid covers about two-thirds of nursing home residents.

Thanks to both federal and state driven initiatives, Medicaid and CHIP eligibility for low-income children is broad and expansions of these two programs have made a major impact on children's coverage over time. Between 1997 and 2012, despite two deep economic recessions, the uninsured rate among children fell by half, from 14-percent to 7-percent, an historic low, while the uninsured rate for non-elderly adults, already higher than for children, rose slightly.

Over half the states now provide Medicaid or CHIP for children with income up to 250-percent of the poverty level, at least. That's about $50,000 for a family of three. However, as is so characteristic of Medicaid, there is noticeable geographic variation, and you can see on this map that states in the northeast and on the Pacific coast tend to have higher

eligibility thresholds, while the southern states and states in the vast middle of the country tend to have more limited eligibility by comparison.

Eligibility levels for adults, while lower than the levels for children, are much higher in the states that have adopted the ACA Medicaid expansion than in the states that have not. And you can see that by looking at the pairs of bars on the right here. In half the non-expansion states, shown in light blue, a parent with income of $8,900 in a family of three, has too much income to qualify for Medicaid, and across the board in these states, adults without dependent children are categorically ineligible for Medicaid regardless of how poor they are.

It's interesting to note that, for the most part, even the states that have not adopted the expansion for adults have expanded Medicaid beyond federal minimum eligibility thresholds for children and pregnant women.

Of course, the goal of Medicaid coverage is to facilitate access to care, and it does this by covering needed services and keeping beneficiaries' out-of-pocket costs very low. On key measures of access, federal data show that Medicaid beneficiaries, both children and adults, generally fare as well as their privately insured counterparts, and they fare much better than the uninsured.

This is not to say that there are no problems with access in Medicaid. Fewer physicians accept Medicaid patients than privately insured patients. And in particular cases, access to dentists, for example, and to certain specialists, is a serious concern. But on the whole, using the experience of privately insured people as a yardstick, Medicaid has done remarkably well, has been remarkably effective in securing access to care for low-income people.

While most beneficiaries get their care from private office-based physicians, safety-net providers are an integral factor in the access-to-care equation in Medicaid. Health centers serve one in seven Medicaid beneficiaries. In addition to preventive and primary care, health centers offer an array of services and supports that are important for the low-income population, such as interpretation, case management and transportation. And most health centers provide mental health and dental care onsite.

Safety-net hospitals are the backbone of emergency and tertiary care for Medicaid beneficiaries as well as uninsured people, and these institutions are also the hub of trauma, burn and other highly specialized care used by all of us.

By the same token that safety-net providers are vital to Medicaid, Medicaid is vital to them. As the pie charts here show, Medicaid payments provide a large share of total revenues

in these settings. Looking ahead, as Medicaid expands to cover more low-income people and demand for health care continues to increase, the safety-net delivery system will be important to sustain and build upon.

I am going to end here and turn things over to Trish and our panel. Thanks very much.

TRISH RILEY: Thank you, Julia and thank you for that wonderful opening. So much of the discussion about Medicaid or the debate about Medicaid is about flexibility and expansion and financing, and it's really wonderful to see those pictures of the real people that it serves, and that's what this panel is aiming to look at.

And I think the other story is how nimble the program has become. Diane reminds us that there are few people who are old enough to remember 1965 and it also—my first job out of college, the Medicaid program wasn't a whole lot older than the ACA is today. It was a new program and elderly people were so grateful for it. They didn't want—the people that I met talked about, yes, there's a nursing home benefit and yes, they'd like home care, but they didn't want to push it. Because it was so—they were so grateful that the Medicaid program gave them hope. When before to be old and poor and sick was to suffer and to die prematurely.

But finally the program grows, the program's nimble. It creates the home and community-based services potential. It creates, the payment, to make Medicare affordable. Later, when the courts and the Congress and the states deinstitutionalized facilities for the mentally ill and people with developmental disabilities, it was the Medicaid program that was there to provide important community supports.

And the memory most vivid to me is when insurance companies were redlining people because of where they lived or what professions they were in when they had tough, tough benefit limits that made health insurance unaffordable for people with this newly discovered disease called AIDs, it was the Medicaid program that stepped in and provided coverage. And today, the Medicaid program has promise for every low-income persons, or people, to be covered by the program. It is a nimble program. It is an important program and it changes as the needs of the population change.

So we have an expert panel here to talk a little bit about how those—how that program has affected different populations. We'll have a little conversation here and then turn to you for questions and comments, so, get ready. And let me begin with Sylvia Drew Ivie.

SYLVIA DREW IVIE: Is it on, can you hear? In preparation for today, I talked with my new brother-in-law. My sister got married at 73, and he's 81.

TRISH RILEY: It's just aging us.

SYLVIA DREW IVIE: And when he was 34 years old, he just graduated from Case Western Reserve and he went out to Tacoma, Washington, to practice as a pediatrician. And that was 1967 and Medicaid had just been passed a couple of years before. It hadn't really taken hold that much yet. So, I said, what was it like? What were the—what was going on with the children in Tacoma, Washington. And he said, well, our public hospital closed in 1967 and there was no place for the children to be served. We had 200 physicians and none of them wanted the poor children in their waiting rooms and so I opened a free clinic. I had a rural practice and I opened a free clinic on Wednesdays to take care of those children who were mostly African American and Indian.

And this is what he told me he found on their first visit. He saw 308 children and he found anemia, asthma, convulsions, eczema, impetigo, malnutrition, ringworm, rickets, scurvy, pertussis, pigeon breast, pneumonia, prematurity, mental and physical retardation, psychiatric disorders and otitis. And those were just a few of the disorders that I

recognized the names of, there were many more that I didn't even recognize.

More than half of the children were behind in measles and polio immunizations. Those that got immunizations got them in the basement of a church. In his rural practice, he saw mostly poor white children. And he found them remarkably suppressed in both height and weight, reflecting poor nutrition, poor access to care and a variety of other problems.

So he was very, very energized to say we have to do more for poor children and he advocated, he testified, shared that data with the state legislature in Washington State. He went to Washington. He met with the then head of HCFA. At HEW he met with the office of the OMB director. President Nixon was in office at that time, and the OMB director said that Nixon had said to him, I want to help the children. I'll do anything for the children. I don't want people to think that it's only the Democrats who care about the children. We care about the children too.

And so he went back and he got help and he got support for the clinic. But it took him seven years to get the private practitioners to be willing to see the kids. So, at the point where enough were opening their offices and they could be seen, then he devoted himself to his practice. That's just one person who was working to help children at that time, but there

were many, many people who were engaged at that level in the early days, who have helped Medicaid to become the program that it is as people use it, and deal with the actual people who need it, and who point out, it's not working, we're not covering enough. We're not reaching enough. We need to do these things to get more help.

We have other problems today despite all the wonderful progress that you've heard depicted in the slides and the presentations. We still have 7 million children who are not insured, and we think 5 million of them could be covered, so we've got to go and get them and get them in and get them covered. We have to get dental care covered. We can't have children with bad teeth. We don't have the psychiatric help for our Medicaid patients, for children or for adults that we need. Psychiatrists just have not come into Medicaid. I don't know why, in the level that they're needed. We are not providing Medicaid for kids in probation camps while they're in, which is the time when we most need to help them and help them with their traumatic lives.

You've heard what's happening in a lot of the southern states and not wanting to cover the adults without children. And the final thing that we have to work on now is really helping health delivery systems to integrate mental health, substance abuse and physical health, because unless you're

integrating those three programs, you're not going to be able to get the Medicaid reimbursement that you need to help our homeless populations.

In LA, we have 100,000 children every month who are homeless. So.

TRISH RILEY: I want to follow up on those issues of homelessness, but let's hear from Elizabeth first.

ELIZABETH TAYLOR: The National Health Law Program has been around for almost 50 years, so almost the whole life of Medicaid and, you know, I'm here as only its very newest executive director. What is fun is to see how many in-house NHeLP alums there are sitting around the room. We've turned out a lot of really good lawyers who have done great work, including Sylvia, sitting beside me.

I have to tell a quick story on Sylvia. When I started in this job, I started looking up previous executive directors of the National Health Law Program, so I went to visit Sylvia in Los Angeles and she was gracious and we had a lovely afternoon. And she told me what brought her into doing health care work in the first place, because she was a civil rights lawyer, and when she got started, there was overt racial discrimination. People dying at the hospital door because an African American man in North Carolina who was shot through the neck got turned away from being admitted to the hospital and

women dying--African American women dying because if they couldn't be treated in the emergency room, and they, you know, they wouldn't be admitted to the hospital. So, you know, we've come a long way in some ways. But in other ways, we still have a long way to go because the health care disparities that we still have in this country are not now based on overt discrimination, but those disparities are still there and the battle is still very much to be fought by this next generation of lawyers at NHeLP and other places.

So, I, being sort of the new kid on the block, also asked people to talk to me about what one remarkable thing about Medicaid I should talk about, and several people, including our newest board member, gave me some thoughts and the consensus is that what's remarkable about Medicaid is not just the numbers that you saw on the screen, but those numbers are remarkable, but it's the essential nature of Medicaid. Medicaid provides health care to the most challenging population, the population with the greatest needs. The Supreme Court in Goldberg v. Kelly described the brutal need for health care that the population receiving Medicaid faces.

And that's what Medicaid does. It's not just health care. It's health care that addresses the needs of a very particular population. And it does it, as Trish said, by being nimble. The children, one in three children in this country

are covered by Medicaid and those children are entitled to coverage of what is medically necessary for them. So, you know, if there's a need for a family intervention and behavioral treatment, that's available under Medicaid. So, it is a type of service that is different from what you would get under private insurance because it is aimed at the needs of that population.

As others have talked about, Medicaid is the main provider of long-term services and supports for seniors and people with disabilities. And increasingly, the good news is that states are moving toward home and community-based services, in part in response to the Supreme Court's decision in Olmstead, but also because it is a better and cheaper way to take care of people who need that kind of service, but to give them the opportunity to be in their homes and in their communities, and Medicaid has allowed the states the flexibility to provide not just health care, but personal caregivers, and other services that enable people to stay in their homes.

So what's remarkable, actually, is that a program this ambitious has survived for 50 years. It has survived because it works. It is the effective way to provide health care to the population that it serves. It is cost-effective and it’s effective in what it provides. But, Medicaid has survived

challenges and there are challenges yet to come, as we all know. You know, there have been efforts in the past to try to change Medicaid from an entitlement into just a source of funding for the states. So, you now, per capita caps and block grants, as Andy Schneider tried to educate me about on one of my first days as the executive director, I get it, Andy, that would change the essential nature of Medicaid.

But, you know, there are new ideas about pushing all the Medicaid recipients into the Exchange, just give them some extra funding so they can afford insurance on the Exchange. And what we need to do is to make sure that what makes Medicaid Medicaid, stays. Medicaid is an entitlement and it needs to stay an entitlement. And it provides coverage to children who are the neediest children, who start behind the curve because of the social situations they face, and as Sylvia mentioned, they're far more likely than other children to suffer from anemia, lead poisoning, hearing problems, vision problems. We have to make sure that those children are getting the EPSDT coverage. The periodic screening and treatment for those conditions so that they can succeed in school and be successful as they move through life.

So, you know, we're trying to avoid just saying no. So, we do need to say no to some of the things that would change the essential character of Medicaid. But we also need

to be part of the conversation. There is going to be, there has to be, a conversation about where long-term services and supports are going. It's 40-percent of the Medicaid budget now, and it's going to get worse as we all live longer. So there's a conversation there that needs to happen and we need to be part of that conversation.

There is a conversation that Secretary Burwell is vocal about and we're all in favor of a conversation about delivery system reform. You know, how do we provide care to millions of people in a way that's efficient, but that doesn't sacrifice quality? We need to be part of that conversation. So, you know, NHeLP will be part of that conversation.

Most important, we need to be part of the conversation that helps people understand that not giving people preventive care through their lives is shortsighted. It's not cost-efficient to have the big coverage gap that we have here, so that people end up later in life suffering from conditions that could have been treated with preventive care along the way. It costs more to provide the care when they get sick, down the road, and we're losing the value of healthy people who could be contributing to their communities along the way.

TRISH RILEY: Let me switch gears a little and ask you to talk a bit about the safety-net. We saw some pretty striking statistics earlier.

FRED CERISE: Thanks, Trish. You know, Medicaid and the safety-net system have worked hand in hand over the years to provide access to millions of people who otherwise would not be able to receive care. And as I was thinking about, you know, Medicaid is about—the story of Medicaid is about individual stories and as I was trying to think of the impact there, and you saw some great stories, it's hard to not think of the bad stories. The things that happened when Medicaid wasn't there.

You know, Medicaid varies state by state. Safety-net systems vary state by state and the amount of support safety-net systems have, and so the ability to fill the gap in these safety-net systems with Medicaid support, DSH support, is variable. And so I, you know, reflecting on some of our history in Louisiana, I can't help but remember the middle-aged guy who was in one of our small hospitals, safety-net hospitals, who while in the hospital getting treated for an infection had a subdural hematoma bleed between his skull and his brain that is treatable, but he needed a neurosurgeon and the medical director at that hospital could not get that person transferred despite calling 18 different places that day, and that person died. He was uninsured. Having Medicaid would have saved that person's life.

The stories of some of our smaller facilities that don't have all of the technology and so there are a number of times when I can remember people that would come into the hospital with a heart attack, that needed a heart catheterization, but it was not available at one of the smaller hospitals, and if they didn't have Medicaid couldn't get transferred. And so we worked like crazy to try to get Medicaid eligibility, to try to find a category in a restrictive state like Louisiana with restricted eligibility, and oftentimes we were successful, because we knew if we got that person on Medicaid they could get the treatment that they needed.

And so, there are still gaps in the system, although I'll tell you, the partnership between Medicaid and with traditional Medicaid DSH and the safety-net system has allowed those providers to provide care for millions of people, and it's not just hospital care, not just emergency department care—But if you look at the typical care in safety-net systems—it’s care for people with chronic disease. And so for people to imagine that someone who is uninsured with diabetes, when that goes untreated and that individual then is at risk for blindness and amputations and kidney failure, and heart attacks and death from diabetes, untreated, that’s what happens. And you can't imagine that those individuals who can't afford care

are somehow just going to make that happen or can get that care through an emergency department because every hospital has to take care of you if you come into the emergency department.

But the safety-net systems over the years have been approaching the care of these individuals with chronic disease on a population health basis. Before population health got—has gotten the moment that it got today, working through Medicaid, working through DSH to provide care to large populations. And so, it's a partnership that has worked over the years, short of universal coverage.

In fact, it's kind of forced some of the population-based strategies because you are working with limited resources, but you are responsible for a large population and you have to think, where do I spend my next dollar that can be most effective?

TRISH RILEY: So, we've listened to this panel, and these incredible stories. We saw the videos. So, it's a wonderful program that does incredible things in a nimble way. Why doesn't everybody love it, the way we do? What's the biggest—you only get one, you only get one choice. What's the biggest challenge Medicaid faces? Why doesn't everybody love it? Okay?

FRED CERISE: I'll go first. I think it's because we're Americans, and we like winners and losers, right? I

mean, we are a country of haves and have nots. And to make everybody the same in health care, for one, it frightens people because they—people, I think, imagine, that they'll lose something if everybody has access and Medicaid would sort of bring everybody to the same level of access. And it's—I think that's threatening to some people. And I don't mean that in a bad way. I mean, it just does. It threatens access for people who perhaps don't understand that there is room to go there, to provide a level of care to everybody.

And then there's all of the stereotypical things about Medicaid that people have. But, in reality, as you know, most people, what, two-thirds of the people on Medicaid, have workers in the family. They just have been priced out of this market.

TRISH RILEY: Go ahead.

ELIZABETH TAYLOR: Money.

TRISH RILEY: Good answer.

SYLVIA DREW IVIE: I think it's become an avenue for the current conflict between the parties. I was thinking about some of the Commissioners that we've lost. We've lost five Commissioners since 1991. And, we had profound leadership by all of those early Republican Commissioners on this body. And they fought for the program. They didn't fight against it and they tried to help us figure how to keep it alive.

That kind of you, you know, joint party leadership is harder to come by today because people like to use it as an example of what's wrong, what's wrong with those undeserving people? But it wasn't always that way. And I think the people who use the program, and the people whose family members benefit from the program, would fight with the political voices today who want to bring it down.

TRISH RILEY: Diane mentioned in her opening about how the program has evolved over time. Several of you noted sort of the social determinants of health,that we all know now, particularly for low-income populations. A home might be a better health intervention than a physician. Sorry, Fred. But as we think about the evolving nature of Medicaid, where does it need to go? What's its next nimble step?

FRED CERISE: Well, since you came after me, I'll go first. We have a group at Parkland that looks at predictors of readmissions and predictors of utilization, and so I'll agree with you. But they looked at studying heart failure readmissions and what they found is that just as powerful a predictor as did someone get their medicines or did they get a doctor's appointment or discharge, or the discharge instructions was, did they have five different addresses in the past year. That was a strong predictor of readmission. And so, to your point, there is so much we can do within the

confines of our traditional health system, but we also know, that when you're discharging someone to a shelter, you have to know, does that shelter have a refrigerator for their insulin? Are they able to get some place to store their medicine so that it's safe? Those types of things that really stretch well beyond kind of how we traditionally think about services that we deliver in our health care domain.

SYLVIA DREW IVIE: We're paying for housing for people being discharged from emergency rooms now in LA because we understand that if we're not discharging them to a place where there's permanent supportive housing, they're going to circle right back into the ER again. So, there are ways, and some people have gotten support through waivers and state options to spend more Medicaid dollars to pay for health services in permanent supportive housing. And I think this is a really positive wave of the future to bring supportive health care in housing so that the two go together. Housing is extremely expensive and we have very little of it for the populations that need it, but if we can combine our Medicaid dollars with what we do have, I think we'll save everybody a lot of money and keep people off the streets.

ELIZABETH TAYLOR: So there is a lot of conversation about social determinants of health and the culture of health, which is very exciting. And I totally agree that there is so

much more that goes into whether people grow up healthy than just going to the doctor. But going to the doctor is really important too. You can't—we're not going to fix the health problems in the country by just bringing in fresh vegetables, fresh. Fresh vegetables are important, but we also need to make sure that people get preventive care.

And so, for me, what needs to happen is that people need to—there needs to be an attitude shift, and maybe, you know, we need to hear from more people, like the young man who talked about working two or three jobs and still not being able to afford medical care, so that we get away from the thinking that certain categories of people are deserving of health care. I mean, you know, we came at these categories in Medicaid because, you know, children couldn't help it and people with disabilities can't help it, and seniors have worked hard, and so they're entitled to health care, but, you know, just childless adults, why should we provide them health care?

You know, we provide people education and that's good for—it's good for our society. It's good for our economy. Why don't we provide people health care? That would also be good for our society and good for our economy and then you couple it with all these other things. But if you just provide the fresh fruits and vegetables and the other things that people are talking about, but don't get people to the doctor so that their

diabetes gets treated or their asthma gets treated, you're not going to break the cycles.

TRISH RILEY: You know, it's interesting to think about the Medicaid program and some of the consternation that surrounds it, about its complexity. And its complexity, in fact, has been in response to these incredibly complicated populations. There's now a community health worker benefit that allows non-professional people to be part of the care planning and Medicaid will reimburse. I wonder if we can speak a little bit—I want to make sure we give enough attention to sort of the inequality and the racial diversity of this country, and Medicaid's role there.

SYLVIA DREW IVIE: Well, you know, one of the nice things about having Elizabeth on the panel is she can talk about the National Health Law Program, earlier, and now I can talk also about the evolution of community clinics because I ran one for 16 years in south LA. And we provided services in 11 languages and gave a health home to people who didn’t feel like they had a health home before. And it was very important, not just for the health care access, but for the affirmation that their lives were worth caring for. That there were people who were glad to see them, who remembered their names, who remembered their children's names, who understood what they ate. Who gave them recognition.

One of the things that I worry about as we expand the business of health care is that we lose that connectivity to people and that feeling of community where you can talk about prenatal vitamins and you can also talk about, are you getting fresh vegetables. I mean, you have to do all of it.

The managed care evolution that we're in is usually not just that warm and cozy, you know? They're not going to ask you, you know, how little Johnnie is, you know? And is Juan's sprained ankle better? I mean, it's just much more—you have a benefit. You can get in here, you can get your health care now. We've got to move on to the next person. It's not that they're mean people, they just have things that they have to do.

Now, they're telling me at the clinic that LA Care, which is giving a lot of managed care patients to the community clinics, they're worried that they're maybe not going to be able to keep up with the paperwork requirements and it's a business, you know, it's a business to do it well and get all your reports in. So, it's not just giving the card to people. It's serving people in a way that they feel recognized and appreciated and supported for who they are. So, as we move forward, I hope we're not going to lose that.

TRISH RILEY: I just heard a story this week about a managed care company that's doing some really amazing things

through their capitation and paying for housing supports and social services, and they don't really want us to know that because maybe that shouldn't show up in an encounter data report, but it's really creative stuff and it's making people healthy.

But I'm sensitive to time and I think it may be time for us to turn —indeed, it would be time for us to turn, unless anybody, any other comments? -- to turn to all of you. And there's a microphone, and don't embarrass us by nobody asking anything or making any comments. There we go.

SHAWN GREMMINGER: Hi, I'm Shawn Gremminger. I'm with America's Essential Hospitals. I want to thank the Kaiser Family Foundation for putting this on. Thank Dr. Cerise for coming. One of our proud members.

I wanted to address one very particular issue, which was actually addressed in the terrific sort of glossy book that you guys put together. You know, Medicaid is absolutely essential and I think, you know, Kaiser has always been really one of the great allies of the program. There's a particular paragraph in there where you talk about intergovernmental transfers and provider taxes. I have the unfortunate role of being the guy who gets to defend DSH and IGTs and provider taxes in this town. It's not–

MATT SALO: (Inaudible 01:01:07).

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

SHAWN GREMMINGER: Matt Salo is with us on this one. It's not always easy, and to be frank, you know, there have been times where, you know, provider taxes and IGTs have probably been used inappropriately. However, they are absolutely, absolutely essential to the foundation of this program. Whether we like it or not, this is a significant way in which states raise money that can be matched by the federal government. Without them, Medicaid truly falls apart in many states.

Again, whether we like it or not, and nobody thinks that it's pretty. I'm concerned that the way that they were highlighted in this, in the, you know, the particular—the way that they were highlighted here makes it looks like they're simply just a scheme and they're altogether bad. So I wanted to make that point and perhaps ask Fred, and you know, you should never do this to your boss, but ask Fred to talk about the role of, you know, of financing mechanisms in the state of Texas and the state of Louisiana where they're actually critical.

TRISH RILEY: And another way where the program is nimble with the DSRIP waivers—with the DSRIP waivers that afford some opportunities.

FRED CERISE: Sure. I didn't realize I'm your boss. That's good to know. Let's talk later. So, I think the DSH—to

your point about DSH, DSH, for the reasons you cited, has gotten a bad rap over the years because, and for good reason though, because states abused it. I come from a state that, you know, made a lot of money years ago off of DSH. I'm not in one now. Right.

But, you know, used for good, DSH is an incredible program. I mean, it's the reason that many of the large safety-net hospitals or health systems have been able to put population health programs in place. It's the reason, you know, the systems that I've been in have, you know, been ahead of the curve on things like electronic health records, because you can invest in your infrastructure to support a population and everything is not driven by the encounter, and you have to have, you know, volume to have a visit and an episode, but that you can invest in the infrastructure to support a population.

And so, a lot of the things that happened to these big safety-net systems now or what you see now among the private industry that are happening with consolidation, trying to achieve scale, trying to acquire physician practices, trying to manage, get control across the continuum, so that you can do inpatient hospital post-discharge and all of the other supports that go along with that, that you have to be able to control if you're going to deliver upon quality and efficiency, right?

And DSH has been a big part of that history in the public system. It's unfortunate that some states really took advantage of it, but, you know, used for good, it's a valuable program.

TRISH RILEY: Other comments or questions? Preferably, easier ones.

JUDY WAXMAN: I'm Judy Waxman, NHeLP along with some other hats I have worn. I just wanted to really make a comment to say that there's another teeny part of the Medicaid program that hasn't been mentioned, which is really crucial to women's lives, and that's the family planning program. So, many states—well, all states cover pregnant women to a higher income level than otherwise, but the vast majority of states also cover family planning, and it has made an enormous difference in the lives of young women and made them—helped them to become, you know, economically sustainable on their own and plan their families, obviously. It's a part that I think will grow and should grow in the future.

TRISH RILEY: Thank you. Important point. I think there's one—there's a comment way back there. Oh, Meg?

MEG MURRAY: Hi, I'm Meg Murray from ACAP and actually LA Cares is one of our members. So I just wanted to talk a little bit about managed care and that, you know, one of the issues in managed care is that our plans really are held to a

much higher standard, that we at least know that there are requirements for quality, where there isn't in the fee-for-service world. And I wanted to, one, point that out. And, then two, for Parkland, actually, Parkland owns a health plan. They're not yet members of ACAP, but I'm hoping they will be at some point. So I want you to be my boss too.

But I wondered if you could talk at Parkland about the impact of owning a Medicaid health plan and how it addresses some of the points that Sylvia was trying to put out —there is a tension, obviously, when you're capitated. But there's a lot of good things that come out of it, as Trish said, in terms of the impetus to deal with some of the social determinants that certain plans are doing a lot in housing. But I was curious from Parkland's perspective, owning a health plan, what have been the benefits to you all, of owning that health plan and where do you see that going in the future?

FRED CERISE: Well, it's a great question. I think, you know, the industry today, you're seeing a lot of consolidation and you're seeing providers, hospital systems consolidate and you're seeing acquisition of practices and people are trying to get at the cap, too, in the health plan because if you can kind of manage from preventive to specialty care to hospital care, post-acute, and have the payer in sync with you as well, you can invest in the right part of that

continuum to really be able to, you know, manage the population and do it most efficiently. So it does, it makes a lot of sense.

So, from Parkland's perspective, we do have a health plan. It's not aligned in the traditional sense, because we don't have inpatient pediatrics anymore. That went away years ago. And so a lot of our patients, our beneficiaries in the health plan, are kids. So it's not perfectly aligned. I'm hoping one day, when the uninsured get Medicaid in Texas, that we'll have good alignment with that population as well. Because to have the payer aligned with the provider, it just makes it—I think it makes it easier to move the needle on cost efficiency, quality, those types of things.

TRISH RILEY: Back there?

MALE SPEAKER: In Brooklyn, we have 14 hospitals that are paid, on average, $3,500 less per discharge by managed Medicaid companies compared to traditional Medicaid rates. We only know this because, occasionally, our Department of Health slips and lets some actual data that pertains to the solvency of hospitals and doctors out. What this creates for us are unstable hospitals and a medical desert where a physician would have to be nuts to set up his or her practice.

Why do we suffer the presence of entrepreneurs, profiteering insurance companies, in a program intended for

those who have the misfortune to be sick and poor at the same time?

TRISH RILEY: Sylvia? Somebody?

SYLVIA DREW IVIE: I don't know how to answer that question.

FRED CERISE: It was a comment.

TRISH RILEY: I think it was a comment.

SYLVIA DREW IVIE: Yeah, I think it was—but I, you know, I think—I think the people who have stepped forward are a mixed group. And we have to work together to support the ones that are there for the right reasons and deal with the ones that are not there for the right reason. I think it's not just on them though. I think that the people who don't step forward to take care of Medicaid patients made the bad guys more, you know, get access to what they're doing. And I think we're all in this together.

You know, everybody has to play their part in order for it to work on both sides, on the Medicaid and the non-Medicaid side. And if the people who opt out just say that's somebody else's problem, then you get what you're describing.

TRISH RILEY: And we have the Systems Panel that can talk about this next. But I do think—I do think it goes back to Liz's point about money, too. I mean, the reality is, this is an enormously large program with a shared federal and state

responsibility. States have to meet balanced budget requirements and so there's always the rub about how much can you afford and where do the cuts happen? And that's the public debate that goes on about Medicaid every single day. Do you expand eligibility, do you cut provider rates? Do you cut benefits? None of those choices are good. Or, do you raise taxes and come up with more money.

And you know, the new solution is, maybe we can think about payment reform and delivery reforms that can bring us the efficiency so we can reinvest in the system in a different kind of way.

And it would be abundantly clear that our time is now up. So, wasn't that a nice segue to you guys? So I thank Fred and Elizabeth and Sylvia and we'll move on to panel two.

DIANE ROWLAND: Thank you. You know, as you put a program together, you try and figure out what topics will be covered where and somehow with Medicaid financing and money never quite disappears from any part of the program. And neither do the people. So, I hope that this panel will continue to talk about Medicaid's role for meeting the health care needs of those with health and long-term services support needs as well as those with preventive services needs and this really is an opportunity for this panel to talk about not only how to go forward with delivery system reform, but the key and

complex issues of federal and state program financing. And I'm sure many of the questions that you just posed will be questions that you'd like to pose to this panel as well.

And I'm delighted that, on this panel, we've asked Sheila Burke, the Faculty Research Fellow, Malcolm Wiener Center for Social Policy and Adjunct Lecturer at the John F. Kennedy School of Government at Harvard University, to be our moderator. And she also serves, of course, as a Kaiser Commission member and mostly we know her from her many years of service in the United States Senate, when much of the legislation changing this program was actually enacted.

And Tom Betlach, the President of the National Association of Medicaid Directors and the Director of the Arizona Health Care Cost Containment System is with us, too, and I know, will provide some perspective as both a Medicaid director, but also in a previous life as a state budget director. So he's seen both sides of the Medicaid equation.

And Cindy Mann, the former Deputy Administrator and Director of the Center for Medicaid and CHIP Services at CMS, until very recently, and now a Partner at Manatt, Phelps & Phillips, will join us to provide, I know, a longstanding, both legal services perspective as well as her perspective in trying to manage the federal side of the Medicaid program.

And Charlene Frizzera, the former Acting Administrator of CMS and now the CEO of CF Health Advisors will also give us the same kind of perspective she told me. She spent 30 years working on these issues at the Department of Health and Human Services and some of its predecessor names.

And we also have with us Alan Weil, the Editor-in-Chief of Health Affairs, where we hope many of the thoughts that are here today will someday appear in print. The former head of the National Association for State Health Policy between Trish's two stints there, or her current stint and her first stint. But Alan, with extensive experience as the Executive Director of the Colorado Department of Health Care Policy and Financing, and also, I'm proud to say, also a member of the Kaiser Commission.

We're going to ask, as we did last time, for Robin Rudowitz, the Associate Director of the Kaiser Commission to come up and offer a few of her always insightful slides about Medicaid, its coverage and financing issues, and then open it up to a similar panel discussion that we had before. So, Robin and then Sheila. Thank you.

ROBIN RUDOWITZ: Thanks, Diane, and to the first panel and for everyone for coming today. It is really an honor and privilege to lay the groundwork for the next amazing panel that will discuss Medicaid's role in the broader health care system.

And as Julia did, I will do a few slides to set it up and then turn it over to Sheila to moderate that panel.

I am sure that most people in the room have seen this slide before that shows the distribution of enrollees and spending in the Medicaid program, commonly referred to as our double bars. However, it would be virtually impossible to set up a discussion about Medicaid's role without a reminder that, on the coverage side, children and adults account for three-quarters of the enrollees in the program, and on the spending side, the elderly and those with disabilities account for nearly two-thirds of the spending. While fewer in numbers, the elderly and disabled populations generally have higher per enrollee costs due to their higher utilization of complex acute care services as well as long-term care services.

More broadly, Medicaid accounts for one in six dollars of spending in the total health care system. Medicaid is the primary, as we've heard before, payer for long-term care services and therefore accounts for a larger share of spending for nursing home care, 30-percent of that care.

Medicaid also has some other critical roles in the health care system, some of which were mentioned earlier. Medicaid provides substantial support for safety-net care providers as well as financing for nearly half of the births in

the country. And the program also covers a quarter of all spending for behavioral health services.

States do have a great deal of flexibility to administer their programs in terms of setting benefits and how they will deliver those benefits to Medicaid beneficiaries. Beginning in the late 1980's states began to expand the use of risk-based managed cared in their programs in place of fee-for-service programs. This shift was really fueled by states' interest in controlling costs, gaining predictability in their budgets and how much they were spending, as well as to improve access to care.

In 2011 over half of all Medicaid beneficiaries were enrolled in a comprehensive risk-based managed care plan and states are continuing to expand the use of managed care, both by including new populations, expanding geographic areas within states where managed care is in play, and, in addition to these expansions to managed care, states are also implementing and enhancing a number of initiatives to both improve quality and outcomes through –pay- for-performance incentives and other mechanisms.

Medicaid's contribution to the broader health care system is perhaps, as we've heard before, most significant in the area of long-term care. As we said, Medicaid is the primary payer for long-term care services, and while overall

spending in long-term care services over time has been somewhat moderate, one of the significant trends in the program is how that care is provided. States have invested and shifted more long-term spending to community-based settings and, as we can see in the figure, in 2002, community-based settings accounted for about a third of the spending for long-term care in Medicaid, and now nearly half in 2013.

So Medicaid is jointly financed, as we have heard before, by the states and the federal government. The federal government matches state spending on the Medicaid program and the share that the federal government pays for the Medicaid program is based on a formula that's set in the law. Under the formula, the federal government pays a larger share to states that are poorer, or the poorer states.

Because of this matching structure, Medicaid has a really unique role in state budgets. It acts as both a spending item as well as a revenue item in states. So when we look at state general fund spending, which excludes federal funds, we see that Medicaid is generally the second-largest item in state budgets. However, Medicaid is, by far, the largest source of federal revenues for the states.

As a result of the financing structure of the Medicaid program, Medicaid can really be responsive to changing needs. For example, as we heard before, Medicaid is a counter-cyclical

program, which means that, during economic downturns, when people lose income, more people qualify for coverage in the program, and that increased demand and increased enrollment tends to drive increases in Medicaid spending.

Twice, the federal government has built on the underlying financing structure to temporarily increase support for both Medicaid and the states during economic downturns. The financing structure has also enabled Medicaid to be responsive to changes in cost of care, new technology, epidemics, such as HIV/AIDs, as well as disasters, including 9/11 as well as Hurricane Katrina. In addition, this structure really helps support individual state choices and policy decisions that they make about the Medicaid program.

However, the financing structure has also produced some tensions between the federal government and the states. And debate about altering or changing the underlying financing structure has been ongoing throughout the history of the program and continues today. This debate often emerges in the context of federal deficit discussion, federal deficit reduction efforts.

At the heart of the debate is, on the one hand, how much the federal government will pay and should that funding be capped? On the other hand is how much flexibility the state should have to design their programs. I think this push and

pull around federal financing and national standards versus state flexibility are some of the true hallmarks of the state and federal partnership of the Medicaid program. And it is likely that these issues will remain on the agenda for the next 50 years, as economic cycles continue, the Medicaid program grows under the ACA, demand for long-term care services grows as demographics change, and as Medicaid continues to play a vital role in the health care system.

So, with that, I will turn it over to the panel and to Sheila.

SHEILA BURKE: On that happy note, we thank you, Robin. That was a wonderful overview of many of the challenges that we're going to, in fact, talk about today, and we touched on in the earlier panel. Thank you, Trish, for the hand-off to our discussion.

Our focus is going to be on the role Medicaid plays in terms of the availability and delivery of health services, but as has been mentioned, there's been no end of debate over the structure of the Medicaid program, over the way it is financed, over the relationship between the federal government and the states, the relationship between the states, the basis upon which we establish matching rates, the amounts that we pay, what we pay higher rates for, what we, in fact, discourage or encourage in terms of the behavior of the state. So there's

very little about the Medicaid program that hasn't at some point in time been at issue.

And so one of the things we want to talk about today is less of that history, although certainly history informs us. It's really about looking forward. And what do we know about what has occurred that will help drive us and drive the program going forward. It has been described by some as essentially a, you know, clearly a complicated, very difficult program, but one that is remarkably flexible, as Trish suggested at the beginning of the last panel and the ability to be nimble as circumstances change, as populations change, as the economic environment changes.

It's also been described, some years ago, as the little engine that could. That it's really done remarkable things over the period of time, in fact, it's been in place. So, today, we are going to focus on those elements of the program, in terms of its service delivery and what we might imagine, what kinds of challenges it will face going forward and how we might address those, and possibly also touch on some of the issues that came up in the course of the first discussion.

So, first, I will turn it over to Tom, to begin our conversation.

THOMAS BETLACH: Thank you. First I'll start with, I feel a little bit like a Medicaid party crasher if there were

such a thing, because in Arizona we're only 33 years old and not 50. So, we've got a few years yet before we celebrate our 50th anniversary in Arizona, but certainly appreciate the opportunity to be with you here today and Kaiser putting this event on behalf of 56 Medicaid directors and the tens of thousands of state staff that work every day to make Medicaid a successful program. It's great to actually take a few moments out and to celebrate some of the success that we have in our program and to look forward, as well, in terms of what those opportunities are.

So I thought that the report was great. I appreciate it. Certainly it will be helpful as I go out and speak to a variety of different classes to share a pretty comprehensive look at the history of Medicaid. A couple of edits that I would offer, since I have the microphone in my hand, would be Medicaid is an important source of funding for Indian Health Services. American Indian Members in Arizona, we have 22 different tribes, 40 percent of the Native American population is covered through the Medicaid program and it's an important revenue source in fulfilling federal commitments with regards to tribal member health.

A second edit, or opportunity that will work to create in terms of broadening the stories around managed care, and not to be an apologist, but in Arizona, we've got a long history

and we always have a standing invitation for anybody that wants to come visit our state, preferably not in June, July or August, but if you want to come in February or March and be one of the 20 plus states that have come out and viewed what a managed care state looks like that's more mature in terms of the type of infrastructure we have in place, I always welcome folks to come on out and take a look at what's going on in Arizona.

So, I love the fact that the report focused on the mix of the state and federal roles and really called it a defining feature, because I think it is part of the underlying fabric of the Medicaid program that makes it so unique. Being a budget director, you obviously get the opportunity to interface with a number of different state programs and there is no program like Medicaid in terms of the interaction between the state and the federal role. And at the federal level, you have no programs that really mirror Medicaid in terms of that type of interaction. So it really makes it unique.

And from my perspective, it reflects and gives states the opportunity to reflect local priorities, local nuances and really come up with local solutions. And though, even though we've had the federalism debate in the United States for 204 years, it plays out even within the Medicaid program. And I think it's a healthy tension in terms of looking at solutions

with regards to the various challenges that are faced by states in the Medicaid program.

So I enjoy getting together regularly with my peers and we talk about the problems that we face, sustainability being one of them, the fragmentation that exists within the delivery system, access to care, the list goes on. The list is similar between states, but what's great is, the solutions vary so much in terms of what our peers are looking at for the opportunities to come up with local solutions to those types of problems within their various states and regions. And so, that's what really, I think, has results in creative juices flowing, in terms of looking at those opportunities and clearly there's always the role of going to the federal government and having those discussions about what type of creative solutions we want to put in place. And I would think that the vast majority of Medicaid directors are going to recognize that oftentimes it's those types of conversations that, even though they have tension involved in it, result in a better solution in terms of who we want to move forward as it relates to making changes and improvements in the Medicaid system.

So as we look forward, celebrating 50 years, what are some of the big opportunities before us in terms of where we have to leverage this creative tension between states and the federal government? So, obviously sustainability is one of

those issues, continues to be a challenge, will continue to be a challenge, for states and the federal government in looking at the Medicaid program delivery system.

Dr. [Ezekiel] Emanuel has a prediction that 1,000 hospitals will close. And when you look at the challenges involved in that, there's a lot of changes going on within the delivery system and managing through that in terms of the Medicaid system and other public programs is going to be a very difficult challenge but, again, something that we'll be taking on over the course of the long term.

Payment modernization, looking at opportunities there, dealing with the fragmentation that exists within the delivery system. I had the opportunity to talk to a mother that had recently moved to our state and I'd explained to her that her son who had developmental disabilities had to receive long-term services and supports from one organization, acute care services from another organization, behavioral health services from a different organization. Also, her son was a dual eligible, so Medicare fee-for-service and Medicare Part D plans were all involved in the delivery of care for the son. And what I found myself doing, basically, was apologizing during that entire conversation.

So, clearly Medicaid directors are looking for opportunities to streamline the fragmentation that exists in

the delivery system. We can't complain about the silos that exist at the provider level and at the payer level when, at the program level, we have so much fragmentation that exists. And so I know that's a goal of many of my peers moving forward.

And then also consumer engagement, as we look at what's transpired in terms of expanded coverage, looking at opportunities to help educate Medicaid members on the broader role of health care insurance, the complicated world of health care insurance in terms of--as individuals move up and out of Medicaid, being able to engage in terms of the broader health care delivery system and the challenges.

And then, finally, it's something that's very important but not talked about very much, and that's the administrative capacity of Medicaid and looking for the next group of champions that are willing to come on and take over the program going forward for the next 50 years, because you have to have that capacity to be successful.

CINDY MANN: A peer to federalism, I'm going to agree with everything Tom said.

So, I thought about remarks to end up with, a little bit of the challenges, but really start with what I think is a significant change that's happened in Medicaid and it's not just a change that's happened over the last three years, although God knows there's been a lot of changes over the last

three years. It's really been an evolution. And I think it's important to call it out, because I think it does define some of the opportunities and challenges as we go ahead.

I think one of the most significant aspects of the evolution of Medicaid, which is often unnoticed, is that it has moved from a public assistance program to a health insurance program. And that's exactly how Tom referred to it, as a health insurance program. And there were, and as Diane's slide shows, there were important steps along the way, probably the first most significant one was the expansion of eligibility for children and pregnant women in the '80s. Right? Totally broke the link to welfare in terms of eligibility, and you saw in the slides that we now have in the Medicaid program average eligibility around 200-percent Medicaid and CHIP 241-percent. It's clearly well above the welfare standards.

In the mid '90's, in 1996, Medicaid was de-linked from cash assistance with respect to parents. Right? It was sort of the last connection from the old AFDC program to the Medicaid program. You used to have to—if you were a parent, you could only get Medicaid if you were — unless you were disabled, or elderly, you'd have to be a parent of dependent children. It was the definition. It's not just the definition of being on—of that AFDC had, but it was actually the act of

being a cash recipient that—thank you, Trish – that prompted your eligibility. In 1996, that link was broken.

And many states started to expand eligibility for parents at that point. The development, and Diane mentioned this too, the development of CHIP, while outside the Medicaid program, I think, had a big influence on Medicaid in terms of really focusing attention on simplifying the way in which at least children were welcomed into the program. Again, less of a public assistance way of doing things, and more of a health insurance way of doing things.

But clearly, the Affordable Care Act kind of finalized that evolution, at least finalized it as a matter of law and we're all still working on the reality. It set up Medicaid, along with CHIP and along with marketplace and the premium tax credits and cost-sharing reductions available for those who enroll in the marketplace, as the insurance paradigm, as the foundation of the insurance paradigm, for those who are not eligible for Medicare and don't have affordable coverage through the workplace.

And it not just set it up and anointed Medicaid as one of those three insurance programs, but it also brought forth really significant changes in how it operated. For the first time in the history of the Medicaid program, it had its own rules about how people apply. It didn't derive those rules

strictly from the welfare program. It used to be, in some states, you had a face-to-face interview. You went to the welfare department, you brought a wheelbarrow with you of all your pay stubs and all your receipts and everything else that was going on. That is not—and it was—you know, it was left to states to decide, but it was really a vestige of that link to the public assistant systems.

Currently, under the rules established by the ACA and really embraced by states across the country, whether they've expanded or not, is a streamlined, single, combined application between Medicaid, CHIP and the Exchange. Simplified eligibility process, verification no longer that pay stubs or whatever else was being required by the data-driven verification, an online system where in many cases, and in some states we are seeing in an overwhelming percentage of cases, a real-time eligibility determination.

So, it is a very significant change and one that is not just like, oh, let's celebrate the changes in Medicaid, but one which creates a framework for thinking about the program and what needs to happen that is very different than the framework, I think, that has existed over the years. Although we still see the fight going on and the tug going on about, is it public assistance or is it not?

So, first of all, let me just say, and this goes to, I think, Elizabeth's comments too, by saying this, I don't mean that Medicaid is like every other health insurance program in the nature. It is always critically important to understand the unique needs and situations of the populations served by the Medicaid program. So the fact that it's a health insurance does not mean it's—, does not mean it to be blind to the particular needs and circumstances of the beneficiaries.

But it does provide a very different frame for how you construct the rules. Think about it now, right? It used to be Medicaid rules, AFDC rules. Thesame. Now it's Medicaid rules, marketplace rules, the same. That tells you a lot already about how you need to think about moving forward. It also changes how you think about enrollment, for good or for bad. Most people, policymakers, think about being on public assistance as something you should not be on for long. You should get off. You should—we should reduce the rolls. You can debate, again, that philosophy, but that's strongly part of the nature of public assistance. That's not the right philosophy for health care coverage. We want people covered. It is a good thing, not a bad thing, to have people enrolled in the program, covered for as long as they are eligible, make sure that there is a payer there for the care that they need.

Make sure they're getting into care early and at the appropriate place and the appropriate time.

So it's a very different framework of how we think about welcoming people into the program and keeping them there for as long as they're eligible, and then, going to Tom's point, too, about some of the challenges, it also makes you think very differently about Medicaid's role with respect to the health care system at large. And states, I think, have been embracing, with gusto, delivery system and payment reform and really thinking about what Medicaid's role is, how it should and maybe shouldn't look like other insurers. How it should align within the marketplace, and how it can do a better job and in some cases, be a leader in terms of moving for a better value.

SHEILA BURKE: Cindy, I want to come back to that after we've heard from the other panelists. But your particular mention of the fact that it is an insurance—health insurance system, but not. And the elements of Medicaid that have made it unique for the unique population that it serves, and particularly given the demographics that we are looking at, and the need to begin to think forward in terms of how we're going to serve that population and what does that service mix look like, and how do we essentially begin to accommodate that.

So I want to be sure to come back to that. Yes, Charlene?

CHARLENE FRIZZERA: First I will say, in the interest of federalism and statism, I totally agree with everything Tom and Cindy said and, as an independent consultant, I totally agree with what both of them said also.

So, you know, I think the thing that I find so amazing about the Medicaid program, I'm going to talk about things a little bit different than other people because I've been working in the Medicaid program, it seems like, all my life. I started when I was about eight, so I've been doing it a pretty long time. And I think one of the things that's important that, you know, I can talk from experience is the impact of the leaders in the states and the federal government in how they interpret and implement the law.

Right? So, the law is the law. But the leaders of the Medicaid program have a lot of influence and power over how that gets implemented and interpreted. So, I don't think there are very many people in this room who will remember these names, but I want to go through the names of these people, just so, maybe you'll talk to somebody older and you can get a little bit of flavor of what I'm talking about, about the different kind of leaders in the Medicaid program.

So, I don't know anybody, so I'm going to start with Tina Nye and Rosanne Abato. Oh, there we go. One—a couple of people. All of us started when we were eight, right? So we're all pretty young. So, Tino, actually, I think was the official first Medicaid program director. We had—Medicaid was just a part of a bunch of other little places and that was the first time they really established that.

Then we go to Sally Richardson and Judy Moore. Judy, who is here, who we should clap for. Thank you, Judy. Becausethe Medicaid program could not have run without Judy Moore helping Sally Richardson. So, we thank Judy for her service.

And then, I would say the most interesting of the Medicaid directors is Mr. Tim Westmoreland. Now, Tim, Tim actually took deputies. Me and Penny Thompson. Tim could not be controlled alone. So Tim actually had two Deputy Directors to help him. Penny then deserts me. Dennis Smith comes along. I stayed with Dennis and became his Deputy. And then I deserted Penny and Penny went to work for Cindy. So, I think what's important, what's important about that list is not so much the history, but the differences of the personalities of the people who ran that program. And each of them, I just would—I want to make sure that we say we owe each of them a thank you for what they contributed to the Medicaid program

because they really did influence it. So, thank you. Thank you, Tim.

And some of the things that I think you won't read in a book or you won't hear through statistics that I think is really accomplishments that make the Medicaid program of yesterday and today really just a program I've always been incredibly proud to be a part of, let me give a few specific examples. So I know Kathy Kuhmerker is here. So I want to tell you a quick story about Kathy and I, and, you know, the flexibility of the Medicaid program to deal with crises is really invaluable. And, again, I don't think we talk a lot about that because a lot of people don't even see it, right? You see the statistics, you see the lobby, you really don't understand what happens, what I call behind the scenes in the Medicaid program. So 9/11 happens. I know—it's all good, it's all good. I promised Cindy I wouldn't tell any bad stories about us. It's all good.

So, 9/11 happens and Kathy Kuhmerker is the Medicaid director in the New York—for New York, and I'm the Deputy Director. Everybody's gone, right, there's nobody left but me and Kathy, calling each other, like, what's going on, what's going on? And Kathy and I decided literally, 9/12, she said, look, I've got a freaking mess. I don't know what to do. I

said, you know what, just take care of everybody, we'll figure it out later. Right?

We didn't think a lot about that. We didn't even really think, like, oh, my God, we might be breaking the law. We just said, okay, just do what you need to do and we'll figure it out later. And you know, it was really pretty remarkable because what we did, really was super important and, you know, made a huge difference to the citizens of New York at that period of time. But you know the beauty of the Medicaid program, nobody ever yelled at us. Right? Nobody really said we did something we shouldn't have done. We knew we had the authority to do whatever we could to make sure that the Medicaid program ran the right way and people got taken—were taken care of during a crisis.

So, I think it's really important to appreciate that in a crisis the Medicaid program really does come, you know, they really do come to the table and they really do serve the need of the beneficiaries.

I think the second thing that I've seen has been a big change over time is data. Right? The use of the data. Like, we started out, honestly, we had no data. We kind of knew what we were doing, but not really. We kind of guessed, and not really. Tom Scully comes to CMS and he says, okay, Charlene, how many community-based waiver expenditures are going crazy?

How come? Well, we're spending more money. He's, like, well, why? Do we have more people? Or is it costing us more money for the services? I said, oops, we didn't know. I said, nobody really knew. Right? So, I think from—from the time when we just did our jobs, we didn't really collect data. We didn't really think about it that much, until the time when somebody said, in order to change the system, you have to collect data. I mean, I think now you can look under Cindy, right, they have a lot of data. They understand the program. They understand the people in the program. They know where the money is being spent. And they know the impact of the changes that they're making based on the data that they have. And I will say in the past we didn't really. Like, we kind of took our chances, did the best we thought we could do with what we knew. But the program today really doesn't run like that. It really does run on good data with good decision making about the impact of people.

The third thing that everybody will tell you, you know, it's a driver of innovation. And that's really been true. I mean, big innovation now with the ACA, it's come to the forefront. But, you know, I was always kind of proud of the fact that people left Medicaid alone in CMS. Like, nobody really paid much attention to us, did they, Tim? Right? We kind of did what we wanted and we said, well, someday somebody

might yell at us, but for now, we just rolled along. Right? We didn't have to deal with OMB very much. We didn't deal with legislative people. Except for the waivers. You know, okay, I am telling a little bit of a tale, but we did a good job.

So, well waivers, waivers we had, but the general running of the program, we generally ran that program pretty much every day and people didn't pay much attention to us. And people didn’t really like that. They thought, well, gee, you know, we want more attention in CMS. Well, wow, do they have it now. Oh, Lordy.

So, I think it's the difference of it becoming a state by state program that, you know, CMS ran with those partnerships to a program now that gets much more visibility across the country and more people pay attention to what's happening in the Medicaid program. And the innovation and the ability that they had in the early days to really figure out how to do things differently is a huge advantage today and really driving Medicare across the country. You know, Medicare is actually looking at Medicaid delivery systems to try to see what they can learn about how those programs are making a difference.

So, the innovation of Medicare, I think it's—you know, they had the ability to be innovative all along with waivers,

but, you know, now with ACA, the innovation has just quadrupled.

The challenges going forward, so, I will say as a bureaucrat who worked there a long time and went through many of these administration changes are a challenge. And it doesn't matter whether it's a Democrat or a Republican. New people come in, they have new agendas and new ideas. It will be a challenge. It won't be, you know, difficult, people there know how to manage the challenge. But you'll see new ideas, new agendas. People have new things they want to create in the Medicaid program.

The challenge is going to be to continue to move and think forward and not to let anything that didn't work in this round of innovation stop innovation moving forward. You know we tend to do innovation and then we say, oh, my gosh, that didn't work. But, you know what, part of that innovation is learning what didn't so you can make it better the next time. So the challenge will be making use of whatever we learned didn't work and making that improve the system moving forward.

Affordability and financing, right, I mean, that's always going to be an issue. Where do you get the money and how do you pay for it? You'll see CMS now is putting some pretty big challenges on the table around how states are

allowed to finance their program. So, that will continue to be a challenge.

And then the last challenge I will say is, we don't really want to let history repeat itself, but, when I read this statement, I couldn't help but make this my last comment. This was back in 1965. "Medicaid is a voluntary program for states and not all states took it up initially." Hmm. "However, access to federal matching funds to provide health care coverage for the uninsured proved to be a strong incentive for states." So I will say states that didn't expand or don't have alternative waivers, hmm, you might want to read that statement. Thank you.

SHEILA BURKE: Thank you, Charlene. I do want to, when we open it up, come back to this discussion of Medicare and the relationship between the two programs and this—what's occurring with respect to that fragile population and the duals which has received so much attention, about the varying roles of the two programs, as we go forward, which have not traditionally been terribly well coordinated. So I do want to come back to that. Alan?

ALAN WEIL: Well to get ready for today, I made a long list of Medicaid's accomplishments on the delivery side, but hearing the tenor of the discussion, I'm setting aside in favor of two stories which will, hopefully, be more enjoyable to

listen to and maybe get the point out in a somewhat more friendly way.

When Medicaid turned 30, I was running the Medicaid agency in Colorado. And one experience I had was the dreaded moment when you run Medicaid, which is that the disability community was holding a protest in the capital and the governor sends me out to meet with them and I proceeded to go meet with them. I thought our state offices were kind of spare, but I went to a basement office with borrowed furniture with people with advanced multiple sclerosis, traumatic brain injury, cerebral palsy, and they basically had one message for me, which was, we don’t really care how smart you are. It's our lives, thank you very much, and as you make decisions, we're the ones who know the most about what the right decisions are. So that's the first story.

The second story is, I was out in Denver and didn't get a lot of visits, but one day on my calendar was a meeting for lunch. It turned out the person I was having lunch with had flown in just for lunch, just to meet with me, from a state that's known as a capital of health care, hospital entrepreneurship that I won't name, working for a for-profit hospital chain that I also won't name, who had also a question for me. And the question was, how much does the Colorado Medicaid program cost? And I said, well, I think I'm

remembering the numbers right, it was $1.3 billion, to which his reply was we'll do it for $1.2.

So, why do I tell these two stories? Because I think they are a reminder for me of what the “public” is, in a public program. There was a kind of accountability, participation, efficacy, for those who are—who had a channel to public officials, elected officials and appointed officials, and how the program was run. And the offer to save the state $100 million which, believe me, we needed, as states always do, had some real appeal when taken purely as a financial proposition. Aside from the fact that we never could have done it, you know, all federalism happiness notwithstanding, we would not have gotten that waiver.

But the concept of, well, we'll do it for you to save you money, sort of leaves out of the picture the purpose of the program, the people the program serves, and the importance of those people defining the program as opposed to just being the recipient of a product created by someone else.

So when I think about the accomplishments on the delivery side, I think of their stories like—like the ones I've told that could apply to all of the most complex and important people who've been able to benefit from what the program offers, the independent living movement, the self-direction movement, PUSH by Olmstead, the development of community mental

health systems, community care for people with intellectual disabilities, the move described of shifting resources to home and community-based services. Diane mentioned the Katie Beckett program, getting very sick children out of the hospital. What's going on now with duals, which is, for the first—as many have been pushing for so many years to try to improve care. The nimble response—the response to emerging issues, nimble is probably an overstatement, in many instances. But HIV/AIDs, the growth of the diagnosis of autism.

These are the real circumstances that affect real people and Medicaid is really there for them, and I am not a romantic or an apologist. I don't think that the delivery system that Medicaid has created for all of these people has been ideal. It has been resistant to change. It, in many instances, still needs to change further. But there's a channel for doing so. There's a type of public accountability that means that when it's not working, there's someone to talk to and someone to—and there's a capital to go to and hold a protest. And that, to me, is a defining feature of Medicaid and its ability to define and re-define the delivery system that I would not want us to lose.

So when I think about the challenges going forward, they are tied to this. I was interested in the managed care discussion of the prior panel. I think we would all agree it

could be done better and worse, and that's—the problem is it's easy to say that, but then it's hard to figure out what you should do about that. But I think the biggest challenge is that as we move to a world where everyone says we're going to pay for value, not volume, and now pioneer ACOs are accredited as money saving, you know, it's a stretch to think that you can measure quality for a Medicare recipient on 33 metrics. It's impossible to imagine that you can measure quality for the kinds of people who account for 42 percent of the cost of the Medicaid program on any of those sorts of metrics.

I was at a meeting recently where someone reminded me the only mental health metric in the ACO package is screening for depression. No question we need to be screening for depression. But knowing the role that Medicaid plays in the mental health system, I think we need to do a little better than that. And so, I think the risk here is that we think we know more about how to hold systems accountable than we do. And the one voice that cannot be shut out of this accountability conversation is the voice of the enrollee, the patient, the family, that's the voice that if we lose, all else unravels, and that’s what I worry about the most.

SHEILA BURKE: Thank you, Alan. Let's begin there. If, in fact, you were given the authority to essentially create a mechanism by which we would measure success or value for

those uniquely complicated circumstances, what would you do and to whom would you turn?

ALAN WEIL: Isn't it time to open it up to the audience? I think we have to go in two directions simultaneously. One is sort of the technical quality measurement enterprise, which is people with—so you think about what's in the ACO measures. They're relatively high volume. A lot of these are very low volume. When you think about the incredible improvements we've made in care for cystic fibrosis, it's because we treated it not as a site-by-site issue but as a national issue with national data. So there's a tremendous need for looking at many of these things from a technical quality perspective with small numbers, with multiple co-morbidities and that's a technical enterprise that I am not a clinician and I would not pretend to tell anyone how to do it. But I know we need it.

The other side is the one that, again, gets a lot of attention now, but I think we're not quite yet up to, which is the notion of the patient experience. And, again, we've—I think we're evolving. This is—I'm not criticizing. I'm just trying to be realistic about where we are. We're evolving in our ability to capture and give credence to the patient's experience. You know, it's not just whether or not the waiting room is clean or the rooms are quiet. It's about whether or

not you're treated with dignity. Whether or not you had control over the care you received. Whether or not the clinicians talked to each other, and things like that.

So, I think we have to come at it from both ends. One is a very data rich side, which has to do with acknowledging that these are complex conditions. By the way, of course, much of the model in quality is about cure. And these are not conditions that get cured. So we have to think about the enterprise differently and we have to think about what patient experience is differently.

SHEILA BURKE: Cindy, on that note, one of the populations for whom that will be, of course, most critical are those who are chronically ill. As the evidence has shown, the bulk of the long-term care in this country is financed by Medicaid. We know there are only about 2 million who are institutionalized. The remainder have chosen to stay in the community. And all of the waiver authority and all of the changes that we've made and also our capacity to manage someone at home has become so much better over time. But the demand on the system, the demand on caregivers, many of whom are, in fact, not financed, who are family members, and what we see in terms of the demographics, and frankly, our successful avoidance of dealing with long-term care, other than the sort of blip where we looked at the CLASS Act. What do you imagine,

having spent time thinking about this, having observed the CLASS Act conversation, where do we go in terms of that portion of Medicaid that's caring for people who are chronically ill?

CINDY MANN: Isn't it time to open it up for questions? Well, if I had the real answer to that or the fully robust answer to that, I'd be able to solve a lot of problems that I don't know that we quite know how to solve. You posed the question as to what will happen with Medicaid and long-term care, and you're absolutely right. That Medicaid is the largest payer for long-term care. And Medicare does very little in terms of having long-term care benefits within its benefit package. And, private insurance does quite little on that front too.

So, a first question is, does it belong in the world of Medicaid? It is a very significant responsibility and a very significant cost. And one which then makes it, I think, difficult for states to handle and to be aggressive about big solutions. That being said, I think that there are some major directions that states and the federal government can be going within the context of the Medicaid program, why don’t we think about this broader? How do we finance long-term care more broadly?

Medicaid does have an institutional bias. I remember the first time I said that when I was a Medicaid Director. I

got cheered by people in the disability community, like, nobody says that out loud. And it's, like, really? It has an institutional bias and what that means is that the way the program was built is you are entitled, if you meet certain, you know, characteristics and you have a certain level of need, to nursing home care, and you are not entitled to the long-term care services and supports that you need if you are able and ready to still stay in the community and in your home.

And we talk a lot about re-balancing, but we've never had a balance. We are moving towards getting to the place where people are served based on what's the best way to serve them as opposed to, oh, do you need long-term care, you go into a nursing home. And if you don't want to go into a nursing home, you don’t get care.

The data that shows in 2013 about 46-percent of our spending is for home and community-based service, you know, I'm willing to bet, you should never bet on data, but I'm willing to bet that when the, you know, 2015 data comes out, we will find that we're at least—we're at least 50-percent. It's a remarkable journey. But it's going to take a lot more, and it's really going to take a paradigm change of looking at people starting with what they need and where's the best place to be able to provide that in the least restrictive setting,

rather than looking at the way the Medicaid program has historically been built.

Some states have moved in that direction. They start with an assessment and they treat home and community-based services and nursing home kind of agnostically – which do you need? And if you don't need nursing home care, then you can have the services in the community. It's nice to say, it's very hard to do and it's expensive, and the big elephant in the room is housing. Because, you know, inside nursing home care is a bed and these are low-income individuals and if they weren't low-income before they started needing long-term services and support, they become low-income after they've been using it for a while.

So, I think a lot more needs to be done to think about the bigger—the solution inside Medicaid as well as what the broader solution is beyond Medicaid.

SHEILA BURKE: I want to talk a little bit about Arizona. One of the conversations in the first panel was the role of managed care. You have, as I recall, somewhere north of 80-percent of your Medicaid population is in the managed care environment. It faces all of the issues that we've talked about in terms of how you manage a population, a diverse population. There have been criticisms that people are under-served, that, in fact, the incentives are perverse. That, in

fact, they don't encourage you to do what's necessary, they encourage you to stay within a budget cap. I'm interested in your sense of how managed care has, in fact, worked in Arizona and what it has taught you in terms of the management of that unique method of paying.

THOMAS BETLACH: Isn't it time for the reception? I would say, you know, Arizona has been involved in managed care for 30-plus years and it's an incremental process in terms of learning a lot from the mistakes that you make along the way. And I remember distinctly a conversation I had with a legislator from another state who had come to visit Arizona and find out how our infrastructure was in place and they had said, well, you know, we figure when we move to managed care, we'll pay, you know, maybe five or six staff to oversee the contractors. And then I proceeded to lay out our organizational structure, which has a staff of 85 that oversee the managed care organizations. Another 10 individuals that manage the data warehouse, an entire infrastructure around data and analytics, and all the infrastructure that you need. And they were shocked. In terms of the type of sophistication and staffing that it takes to oversee managed care contracts. And, at the end of the day, that's what the state has to do, is manage that contract with a managed care organization and laying out all of the expectations, how you're going to measure

those expectations in terms of insuring access to care, and appropriate care being delivered. And then holding the plans accountable in terms of meeting those expectations.

And if you write a crappy contract, chances are you may not have great managed care. But if you are thoughtful in terms of how you want to move forward, if you have the appropriate oversight, and much like the state-federal role, I have found, in our experiences, that we often can move forward in terms of getting better outcomes when we actually collaborate as well. So take home and community-based services. Arizona has 85-percent of its population that's at risk of institutionalization in the community and some of that was generated by the success of our managed care organization and working in partnership with the state in order to achieve that.

SHEILA BURKE: Charlene, I want to turn back to your experience pre- and post-ACA.

CHARLENE FRIZZERA: All right.

SHEILA BURKE: In terms of the impact on the program, the transformation that may have occurred as a result of the changes in the ACA. Cindy walked us through sort of all the remarkable things that have occurred in terms of breaking the linkages with cash assistance and really looking at the individual rather than the other programs they belong to. I

wonder what your observations were in terms of how the impact of the ACA has begun to transform the program and what you imagine, going forward, that will mean?

CHARLENE FRIZZERA: Sure. So I think what the ACA did, it really put more federal legislative and regulatory requirements on the program. So, in some ways, it gave states more flexibility, in other ways, it gave them less, right? So, it had more requirements for the Medicaid program than in the past. But it also gave them a ton of new ideas and new ways to do things. You know, all of the grant money and rebalancing and, you know, all of the money they put in in helping them trying to figure out how to be innovative. So, I think it did a little of both, right? It restricted them to some degree. And they said now you all have to do certain things that you didn't have to do before the central health benefits, incorporating mental and behavioral health, and, you know, it did, but, again, it came with some money to help them, you know, figure out how to do that.

I think, you know, I think the ACA really, for the first time, took a look at the program and took a look, I think, at the people in—the people who need services. Instead of just, again, defining the Medicaid program as some group of people with some definition, I think it didn't do that. It said, so, who doesn't have coverage? Who are these people and

what do they need and through the Medicaid program, they found ways to insure them. So I think it expanded the people that you would put in what we call the Medicaid program today.

SHEILA BURKE: Okay. I'm going to open it up for the audience. While we are identifying hands, with questions with mics, do any of you want to comment on that or anything we haven't touched on, while we're waiting for questions? There's one over there.

AMY HARBAUGH: I have a question.

SHEILA BURKE: And, I'm sorry, would you identify yourself as well, please?

AMY HARBAUGH: I'm Amy Harbaugh. I work for the Bureau of Primary Health Care at HRSA, and I used to work at CMS in the Innovation Center. So, what has been impressive to me with health care reform is the amount of data for Medicare that's publically available that anyone can get. And I would like you guys to comment on when you think Medicaid data will be available at the same capacity.

CHARLENE FRIZZERA: I would like to make a comment about the data. So I agree with you, there's a ton of transparency on data on the Medicare side. I think that what we're seeing is it's a lot of data, right? And I think, you know, it's good and it's bad. It's good to have the data, but for people who don't understand it, there's a lot of

misinterpretation of the data. So I think there are good and bad sides of the data being more transparent. I think, you know, from the consumer standpoint, right, I mean, to the degree I think CMS has done a really good job of trying to make that as consumer friendly as they can, which is really who they want to look at some of the data. So I think, you know, there's been a lot of good data out and I think they've done a good job of making sure consumers can use it. So I think, there's always the good and the bad of the transparency of data without education about what the data means.

CINDY MANN: So high priority, at least during my time there, to move to a more robust, timely, accurate system of having data. It's a lot. It's not an excuse for Medicaid going through 50 years without data at the federal level. But it is a lot easier to do it in Medicare. Medicare, it's a federal program. They run that program. The claims are paid, you know, you should have the data. It's a lot more complicated in many respects in the Medicaid program.

And I think there was, for years, this sense of well, the feds shouldn't be pushy about telling the states what to collect and how. I think that has changed from both the state and the federal perspective, but I'll let Tom speak about the state perspective. I think there's a broader embrace about the importance of it, the importance of some uniformity, importance

of some consistency, give us some money to help us finance because it's a big lift to do it. People from CMS who are here can speak to the moment, but I think in this calendar year, shall we say, you will see a very different amount of data coming out from states that is literally being loaded as we speak and it will be available soon with greater opportunities for the public to look at it as well as for more analysis locally.

Tom has really been, I think, a real believer and leader in it.

THOMAS BETLACH: Very much so. And I—one of the rewards that you get is a call from GAO and HHS, OIG and a bunch of other auditors, your data is so rich. We just, you know, we really enjoy Arizona's data. We're doing an audit on this, we'd really like you to participate, as if you can really say no at that point in time, and there goes your data again for yet another audit. We've got about eight of them consecutively going on right now.

So, you know, we firmly believe in terms of trying to be as transparent as possible, I think, when you go and look at a variety of different state websites, there's a lot of information available that doesn't necessarily help, and having a central place to conduct analysis or to do comparisons and to Cindy's credit and CMS's credit, you know, they're working

towards creating new systems and even just the simple information around eligibility. You know, you think it would be simple to come up with an eligible number, right? But there's all kinds of definitions of who's eligible at any given point in time. Did you take everybody over the course of that? Is it just a point in time? And, you know, today, you can go out and you can see how many individuals are enrolled in Medicaid and how many that were, you know, back before the ACA started. So, I think that you're seeing a recognition from states that obviously data is very important and we're trying to make available on individual websites and then we're working with CMS to make more data available at the federal level.

ALAN WEIL: I don't share Charlene's ambivalence about the data release, but I—as someone who reviews a lot of papers, I do want to remind you that the most common sentence I can think of in the papers we receive on Medicare is, we're looking at Part A and Part B, but we excluded Part C, the Medicare Advantage, because we don't have those. And Diane, at the outset, reminded us, as did others, that managed care is the dominant delivery model in Medicaid and so there is a little apples to oranges here. We actually don't have great Medicare managed care data.

And the second item is to think about the provider mix. Again, there are a lot of what you might consider non-

traditional, non-mainstream, health care providers who are paid by the Medicaid program who are—who don't get meaningful use incentives who are not—don't have electronic health records because their core business is not medical care. And I think if we're—if we want a robust picture of people's care, we would want that, and that requires an investment more than just at CMS or even at the state level.

So, I think we've made great progress. I don't think anyone would disagree with the need, but I don't think the contrast is as large as it seems if you keep the managed care element in mind.

SHEILA BURKE: We have a question back here, I believe.

JUDY MOORE: Hi, Judy Moore. Oh, so many places I could go. But I have a relatively narrow, but very important question I'd like to ask you all to think about, having to do with the very large number of people served by Medicaid who have behavioral health needs as well. And I know Tom is working towards integration and I know it's an important future endeavor. So, I'd like to hear a little comment on that.

THOMAS BETLACH: Since you called me out, I'll start. You know, we have been dealing with integration and looking at the delivery of behavioral health services and in the report have identified Medicaid as the payer of 25-percent of behavioral health services nationally. Obviously a very

significant role. And so, I talk about integration being really three different levels in terms of improving the delivery system for the members that we serve. So, you have integration at the provider level, integration at the payer level and integration at the administrator level.

And when you look at a state like Arizona, and many states, you have behavioral health separate from the Medicaid agency and never the twain shall meet in many instances. Talk about tension sometimes that may exist. And so, you know, I think states are looking at the opportunity to work more closely with the behavioral health organizations and in the case of Arizona, actually after 20 years' worth of debate, our legislature voted unanimously to integrate the behavioral health organization into the Medicaid organization. So that's one level and then you've got the payer level. And we're looking to integrate there because so often times when you can integrate the delivery stream in terms of the payment, then you can work more closely with providers to really come up with an integrated system at that level as well.

So, on top of that, we're looking to provide other funding sources for individuals with serious mental illness in terms of housing and employment support, case management and really have a single organization that's accountable for the delivery of all services. So that's just an example of one of

many different options that states are looking at. It's a very important issue for state Medicaid directors.

SHEILA BURKE: To my left. Oh, yes, Alan, I'm sorry. Go ahead. And then to my left.

ALAN WEIL: I want to jump in. You know, I think it's a very exciting time. And there are two things that are going on that I think are worth raising about it. One is that if you look at how the mental health delivery system has been set up over the years and then Medicaid coming in to become such a large player, you still have this huge differentiation between people who are Medicaid-eligible and people who are not accessing a system. And the service availability and the payment sources were quite different for those two populations.

One of the major implications of the Medicaid expansion is, in those states that did it, to dramatically reduce the number of people with mental health needs who are uninsured and therefore making it a lot easier to think of this as an integrated system and integrated population rather than having to think this person has a Medicaid card and therefore they—we can get payment for these services. These people we can provide community mental health services, but it comes out of a block grant stream or some other stream. So I think it opens the door to the kind of financial intermingling that we need to

have integration, even within the mental health system, much less between mental health and physical health.

The second, I was struck, Cindy, when you talked about re-balancing and we never had balance. I also think we have to remember that we are undoing the imbalance in mental health. When I ran Medicaid, in Colorado, we were carving out, and we thought that was a good thing. Remember? Any of you remember? A few of you remember that, right? We thought it was a good thing because general health care managed care organizations didn't really know how to manage mental health conditions. You need expertise, you needed knowledge, you need a whole different—we thought we were were doing something wise. It wasn't even just to save money, although, you know, of course, there was that, but it was actually better care. And we are now having to reverse what we thought was a good policy, and maybe at the time was, but now understanding that we built in structures and institutions around a model that now is counterproductive.

SHEILA BURKE: Okay. We're going to go to a lightning round in our few minutes left so we can get as many questions as we can. A question on my left.

ANNE DWYER: Hi, I'm Anne Dwyer, I'm with the Senate Finance Committee, and I just wanted to echo Shawn and—

SHEILA BURKE: The perfect committee. The committee of all—

ANNE DWYER: Thank you. I agree.

SHEILA BURKE: The committee of all strength. The top of the food chain.

ANNE DWYER: But I'd like to echo Shawn and Meg and say thank you to our panelists and to the Commission for putting this event on today. And I think I may be one of the last questions. I was hoping maybe we could end where we began. It's no big surprise, I was not around in 1965 for the creation of Medicaid, and I just want to say thank you for the dedication for the leaders here, with Cindy and Diane and Tim and Matt and Andy and everyone else in the room that we have this report today. So thank you so very much.

But really what I would like, since I have you on the stage, is maybe if each of you would be willing to give a piece of advice to the future, the next generation of Medicaid leaders and kind of what they should do next?

SHEILA BURKE: Okay.

THOMAS BETLACH: Aren't we starting with them and going down?

SHEILA BURKE: This is a lightning round.

THOMAS BETLACH: Okay.

SHEILA BURKE: One point of advice.

THOMAS BETLACH: Boy, one point of advice?

SHEILA BURKE: One point of advice.

CHARLENE FRIZZERA: Can I start?

THOMAS BETLACH: Yes.

SHEILA BURKE: Yes, you may.

CHARLENE FRIZZERA: So my advice is, don't forget the people you serve. Really.

SHEILA BURKE: Alan?

CHARLENE FRIZZERA: And I say that coming from a federal government employee. Ex-federal.

ALAN WEIL: Well, since you took mine, I will say, familiarize yourself with the people who actually provide care. It's a really complicated world and it's easy to forget that they are out there and they have ideas and they're not always adversaries and you need them for the program to succeed.

CINDY MANN: I want to talk about the people too.

CHARLENE FRIZZERA: That's why I went first. I knew everybody was going to say that.

CINDY MANN: You know, I would say at the federal level, the advice is always remember that the success of the program depends on the states' ability to do it and to pull it off. And that while I'm a strong believer in federal standards and federal rules and minimum standards and all those kinds of

things, at the end of the day, the states are running the program and you got to make it work.

THOMAS BETLACH: So this is repeat, but I'll steal it anyway, it's probably the most influential person for me, personally, as it relates to Medicaid was an individual that I worked with who passed away many years ago from breast cancer, and she said, always remember what the impact will be on the member, and continue to think about that with every decision that you make.

SHEILA BURKE: And mine would be, not surprisingly, don't underestimate the politics, at the state level, internal to the state, as well as between the states. Set aside the fed, state, but just remember the politics among states can be enormously complicated. And I will turn it back over to Diane.

DIANE ROWLAND: I want to thank our panel, very much.

DIANE ROWLAND: And I want to thank our panel. I thought Anne from the Congress gave us a perfect opportunity to transition from this session and the last session to the conclusion so that we can then go down and do the reception, which everyone has, I know, been waiting for. But I think it's also important to note, as we close, that as we did in our conclusion, when Medicaid was included as part of the Social Security Amendments of 1965, it was not actually a very well thought-out inclusion. And so I think it would be very

unlikely that the authors of the original Medicaid law could ever have imagined that the Medicaid program would come to occupy the integral place it does in our health care system today.

They could not have predicted that federal and state policymakers, as we've talked about, would look to the program again and again to cover the growing number of uninsured and underinsured Americans, or that it would become the nation's de facto long-term care program for people with disabilities and senior citizens. Or that it would be a major source of health care financing and innovation. It's really by virtue of its federal state design and its financing structures that Medicaid has been able to respond to diverse and changing societal needs over the course of 50 years.

In its expansion to fill widening gaps in health coverage, its positive impact on access to care and community integration and its role in improving care for people with complex needs, Medicaid is largely a story of adaptability, resiliency and accountability. While uncertainties are inevitable given Medicaid's ongoing policy debates, demographic pressures and factors in the health care system overall, we know that Medicaid's service and record as our nation's health care safety net bodes well for future generations of Americans as the Medicaid program begins its next 50 years.

And we will remember, as we always try, that it is about the people and their needs that this program exists and the rest of us just have to make it work.

So with that, I want to thank everyone who participated today with us in the program to all of you who attended, to especially Barbara Lyons and Julia Paradise who helped put together the materials that we have here today. To all the Kaiser staff who we kept badgering to make sure there were people here and that this would work and that we would be able to really say that Medicaid has been here for 50 years. We've been trying to study it for 25. Twenty-five years ago when we started, we said Medicaid was at a crossroads. I think it's crossed the first crossroads and it's on to the next.

So, with that, thank you to everyone, let's give another round of applause to everyone who is here, and go downstairs.

[END RECORDING]