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Medicaid Reform: Block Grants and More

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Recorder: JAMES N. ROBERTS

Summary: The panel will give the audience an update of the current status of Medicaid reform efforts by the White House and the Congress. Depending on the pace of the White House and Congress' ability to compromise, the audience will be updated on the effect of these changes or, alternatively, be presented with both sides of the issues and their likely outcome.

Mr. James N. Roberts: What is Medicaid, what's going on currently and what's likely to happen are some of the topics that we will be discussing. Why is Medicaid of interest to actuaries?

A number of us are working with organizations who are providing Medicaid services or involved in financing Medicaid services, or working in the public sector. Medicaid is of great interest both financially and politically these days. Clearly, the Welfare Reform activities of the last few months have had an impact and will continue to have an impact on Medicaid. We are using a single term to describe what is really 56 separate programs. Each state, Puerto Rico, and other territories have separate programs, and there are a number of populations that receive services. Aid for Families with Dependent Children (AFDC) is probably the

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largest single program by body count, but certainly not the largest in terms of dollars. There is a variation in how the various populations are addressed by state.

Medicaid provides both acute health care services and long-term-care services. Clearly, something's going on or maybe 56 things are going on and I think it's interesting, at the least, and probably important to try to monitor some of this and find out where, as a profession, we may be able to contribute. Medicaid has been doubling in total expenditures about every five to seven years, and that is of concern and probably the area where we may be able to contribute.

We're fortunate to have two people to address these issues. We were successful in recruiting representatives from both the federal government side and the state side. I think each perspective may be somewhat different. To speak about state government, we have Patricia MacTaggart who is the director of the Medicaid program in Minnesota. Eugene Grasser, who is the associate regional administrator for the southeast for the Health Care Financing Administration (HCFA), will discuss the federal side. Gene has a number of things going on in his region and, in particular, Tenn Care is probably the one that's gotten the most play.

Mr. Eugene A. Grasser: We have the eight southeastern states of the Health Care Financing Administration, which is about the largest region in terms of beneficiaries. It wasn't that way when I came there years ago, but the growth has been tremendous. As Trish and I were discussing earlier, we have to approve the contracts. Of course, the rates are included in the contracts, that in the regional office from the states, so we've met more actuaries in the last two years or three years than we've seen in our whole life. Because there is such a move toward managed care, that's what we'll be talking about most.

The first thing I need to tell you is that HCFA is part of the Department of Health and Human Services. It manages Medicaid and Medicare, and it is the largest purchaser of health care in the U.S. I should add that HCFA is trying to become one of the best purchasers for the 75 million people it serves. We've realized that the day of simply paying bills is over; we're trying to find the best purchasing strategies we can. In 1995 we served about 37.5 million people in Medicare and another 36.5 million in Medicaid. In 1994, the last year for which I have complete federal budget totals, we represented 17.4% of the entire federal budget in the Medicaid and Medicare program. That's up from 1980 when we were about 59 billion and we only represented about 9%. By 1995 we were running closer to 17% of the federal budget. When we add the dollars that the states contribute, the two programs came to $323 billion in 1995. Actuaries are probably computing that to be about $615,000 a minute. The numbers are staggering.

The subject will be Medicaid managed care. I thought I'd tell you about who we serve. Of the 36.2 million people, we serve about 18 million children. That's one-third of the babies born in the U.S. We serve about eight million adults in AFDC in poverty-related families, six million disabled, and about 90% of all the people with acquired immune deficiency syndrome (AIDS). I think it's fair to say Medicaid is the insurer for the disabled. We also have four million elderly, and although most of those people are also in Medicare, because of the costs that Medicare does not cover, Medicaid buys them into Part B. Medicaid pays, of course, the co-insurance, and deductibles, and uncovered services such as drugs and the bulk of the long-term-care costs. Thus, Medicaid actually covers considerably over half of the cost of these beneficiaries.

As you can see, there's a great disparity in expenditures. We spend about $1,400 a child and about $2,250 per adult. But we spent $8,300 on each person who has a disability and about $9,800 for beneficiaries who are elderly. That's the famous 70/30 rule. So even then though most people consider Medicaid strictly a Welfare Program, the bulk of the cost is not tied to the AFDC population, which is about 70% of the population; the costs are actually tied to the elderly and the disabled.

Now the number of beneficiaries has really grown. Medicaid started in 1967 with about 10 million AFDC children and now we have 36 million. We've had immense growth in population—an increase of about 250%. If you look at the expenditures, they far outstrip the growth in population.

Now what do we buy for those beneficiaries? Despite what I think have been excellent initiatives in the area of preventive care, we've expanded AFDC up to 185% of poverty for maternal and child health, particularly pregnant women. We've had tremendous efforts to deinstitutionalize people and move them to a more reasonable and humane place to live in the community. Medicaid is still, by and large, an institutional program. Our hospital services and our long-term cost, after putting the disproportionate share into the Intermediary Care Facility for the Mentally Retarded (ICFMR) for the disabled, run about 65% of the program. The nursing facility costs alone run about 26%.

Now we can get to Medicaid managed care which was really the thrust of this particular story. In 1995 about 11.6 million of our beneficiaries, or 32%, were in managed care and that number has grown at an astounding rate. The numbers are coming in for 1996, and they'll probably go up another 50% or so. Now most of the growth in managed care has really been in the area of the AFDC population, but just remember that's 70% of the population. However, we've seen a great deal of movement to carve out areas such as mental health or services for the disabled.

We really have three types of managed care and, as you might imagine, I'm sure the government has a variety that you never see. The first type we have is primary care case management, and under that method, we have a gatekeeper. That gatekeeper is paid a monthly fee to, if you will, be a gatekeeper to the system. The fee is usually about $4 a month per beneficiary to control the expenditures for hospitals, specialist services, etc. These physicians are paid a fee-for-service when they actually treat someone, and there's no financial risk to the physician. The next thing we have are the limited risk health plans which are fairly popular in some states where there is very little managed care or very little penetration. It was to be the centerpiece of the statewide health care reform waiver that South Carolina was planning and may eventually still start. Finally, we have the full risk capitation plans. About 44% of the people nationally are in health maintenance organization (HMOs), about 32% are in the limited risk health plans, and only about 23% are in the primary care case management programs. But when you go to an area such as the southeast, you notice it is entirely different. In the southeast, almost all of the HMO action is in Florida and Tennessee. On the freedom of choice waiver side, the primary care case management waivers, we have a waiver in almost every state and I think it's fair to say that, by the end of 1997 or 1998 the entire AFDC population will be in one of these waivers if they're not in a capitated HMO program.

Jim asked me to give you an update on Tennessee and Tenn Care. I don't know how many of you know of Tenn Care. It's an interesting case, in market share. Tennessee had in 1993 one HMO with 35,000 people and they received a health care reform waiver from HCFA that allowed them to go to a managed care program and to require people to join managed care. And then it also gave them the option to include the uninsured and the uninsurable who did not meet our eligibility criteria if they stayed within our overall budget neutrality.

There are about five million people in Tennessee. By the time they added the uninsured at about 400,000 people to the more than 800,000 people on Medicaid, Tenn Care controlled 24% of the entire market in the state. So if you wanted to play the market share game, this was the only way to play.

On January 1, 1994, they moved the entire 800,000 people into HMOs in one day. I wouldn't recommend that for the timid. It ruined a year of my life, too. Within about three months, they moved in the uninsured. Now for all its warts and all the eggs they broke making the omelet, it seems to be working.

There are about 1.2 million people enrolled. The enrollment is closed except for the uninsurable or people with pre-existing conditions that can prove they can't buy insurance. Their expenditures are below all estimates of what Medicaid alone

would have cost them, so the enrollment closing is predominantly a state funding problem. They are considering re-opening it, because if they don't they would probably have to again expand the disproportionate share payments to hospitals for charity care as less and less people would be insured.

They had every problem you can imagine. When they first started, their hot line was receiving 50,000 calls a day. They had 200 operators in basically a converted warehouse answering them. It's now down to about 2,000 calls a week and by June 1996, it was down to about a two minute waiting time which is probably good by anybody's standards. They've been very innovative. Believe it or not, they've been able to reduce the waiting time by getting a little more consistency and less turnover in the staff answering the phone. They're now using inmates in the women's prison.

They charge no premium for Medicaid but they charge premiums for over 100% of poverty, and they will subsidize to 300%. The uninsurable could come in at any level of income and simply pay whatever Tennessee's Tenn Care was costing them. I think they plan to raise the premiums next year for the uninsured, which is for the population between Medicaid and 100% of poverty. They've had many problems with enrollment fraud and they think this will be a monthly reminder. It will check to make sure that they're, in fact, Tennessee and not Georgia enrollees. It will look for fraudulent enrollees.

At first it was an absolute nightmare. The first list that came into the state from the various agents had Saturn employees, G.M. employees, and certainly insured. There were prisoners on the list and there were 8,000 people in one homeless mission. In defence to the state, the people that turned those lists in are now themselves prisoners of the state of Tennessee. They've also had to change the eligibility verification because when you're dealing with people between Medicaid and 100% of poverty, it's very hard to get any information on them. The normal credit bureaus do not work. They don't have Master Card or Visa. They've had a terrible problem with that.

Let's discuss the rates. The rates in Tennessee varied depending on who you talked to. If you talked to the state, you know that it paid 78% of the fee-for-service level, not the whole fee-for-service level. If you talked to the managed care organization it was 68%. Basically, the fight was over whether the state used one million Medicaid enrollees a year. The managed care plans did not agree with them that there were 850,000 unduplicated months, every month and that's what it should have been based on. But since 1995 and 1996, they raised the rates 9.5% and they raised them another 4% in the first half of 1996. So by mid-1996 they'd gone up about 14% since the beginning of 1995. Then that brought it to a capitation rate

from somewhere around $101.08 in the beginning of 1995 to the current rate, which I think is about $117.36 a month. Now that rate is not quite what they're paying them right now because they carved out mental health.

They have two behavioral health organizations that have contracted to provide the mental health. They pay them $7.53 a month on all 1.2 million lives, and I think there are 57,000–58,000 people actually receiving mental health services in the system. They also have some additional pools. You knew that would be too simple not to for a government operation. Since the inception, they have been trying to pay $40 million annually for adverse selection to various plans. They are now working with us and some consultants to try to see the best way to distribute those funds. This year, they added another 1%. It will be around $55 million of a premium withhold to the plans to cover the new protease inhibitors for AIDS, which will be a tremendous cost for some plans.

They've also in the first two years paid about $20 million to large providers. They paid about another $10 million to doctors from a malpractice fund that saw a large percent of Tenn Care. At first, some participating plans were really preferred provider organizations (PPOs), particularly the Blue Cross Network, but everyone has or is in the process of instituting gatekeepers, so they'll pay about $15 million into those pools this year to the various providers, but that will end in 1997.

The state has done a great deal of audit work through this process, and the state auditor has audited for financial solvency and profitability. He was having a great deal of trouble with exactly what the dollar value of the incurred-but-unreported expenditures were. Particularly during the start-up period, many of the plans denied claims, so they went in to study the financial solvency based on the incurred-but-unreported as well as the denied claims. On the data side, Tennessee collects a 100% encounter data set from the plans. As you can imagine, it was a nightmare. You had 12 different managed care organizations submitting data. They were all submitted to the old fee-for-service fiscal agent who, of course, was not paying bills and did not have the threat of a perfect claim or no payment. To compound the problem, many of the plans subcapitated to their providers, so the data quality was even worse coming in from those providers.

We provided Med Stat to help them with the database. They've created an off-line, analytical database. I think they have the first year of fee-for-service in there, 1993, and the last two years of the encounter data are in the file. It's an off-line rather intuitive system of about 73 gigabytes. It seems to be very analytical, and it has worked very well. From that they will then develop some Healthplan Employer Data and Information Set (HEDIS) measures with which they will then begin to issue report cards and better manage the plans.

Where are they going in the future? They continually talk about controlling long-term-care costs. I don't know whether they'll attempt to capitate that. They've talked about getting competitive bids for the managed care rates. Whether they'll save a great deal of money I don't know, but it would probably get them less in the current 11 plans, than it would get them statewide. It would probably, for the first time pull that carve out back into the plans themselves and make them responsible for mental health. They currently have four statewide plans, assuming we approve the network on the forth, and a total of 11. There are at least five in every area. At first there were not. There were only two in west Tennessee and there were some terrible problems. I can tell you that the staff in my office called all 400 providers in west Tennessee to see if they were participating or not, so there were many start-up problems.

But now that I've told you where we've been and where Tennessee is going, I think it would only be appropriate that I tell you what HCFA's agenda is for the future in managed care. Our agenda really reflects quality and accountability of our contractors. This particularly applies on the Medicaid side in some states such as Tennessee, where people are mandatorily assigned to plans. There's usually choice, but it may be closed by the time they get there. We clearly need outcome measures, and we need to measure the quality. Our agenda clearly reached a consensus that outcome measures are far better for Medicaid and Medicare than the procedural things we used in the past. We're trying to develop a set that will minimize the reporting burden. Now I know that sounds odd coming from the federal government, but we want to get a consistent methodology that doesn't really burden any of the particular plans.

A perfect example, and Trish may mention it, is that HCFA has worked very closely with the National Committee for Quality Assurance (NCQA) on developing HEDIS. HEDIS is originally an outgrowth of the northeastern employers trying to determine what value and what services they were getting from their plans because they were paying money out and had no idea what was happening. As a result of that, they developed HEDIS. It was originally for the employed population which differs greatly from ours. It measured quality of care, member access, satisfaction, membership, and utilization, as well as finance and health plan management. HCFA chose HEDIS as the template because it was in the industry and we clearly believe that the first step toward coordinated quality care is to get uniform, consistent data. We would want that vertically from year-to-year over plans and horizontally across plans, as well as even, hopefully, across states.

The original HEDIS was too process based, and it did not meet the special needs of our beneficiaries. For example, it didn't have very good maternal and child health measures for Medicaid and such things as diabetes were not included for the

Medicare population. As a result, we worked with the states, NCQA, managed care plans, and consumers to develop a Medicaid HEDIS in January 1993. The new Medicaid HEDIS includes prenatal care, well baby, and well child visits, as well as access indicators such as obstetrical and prenatal care. It has some measures for mental health and substance abuse. HCFA then funded an NCQA committee to work on HEDIS for Medicaid, and this included representatives from plans and purchasers and consumers. Again, they were trying to get HEDIS measures that would improve health status, assist plans in quality improvement activities, and inform beneficiaries. A key goal of HCFA is to get report cards out.

NCQA then came out with a request for the measures for HEDIS 3.0 and the draft was issued in the summer of 1996. We feel that most of the Medicaid states that are using 2.5 will evolve to 3.0. It is HCFA's plan that the Medicaid plans begin reporting their progress in 1997. I don't know whether that date will be met. In addition to the HEDIS, HCFA has been, as I said, in Tennessee, particularly in our health care reform waivers in Arizona, Hawaii, Oregon, and Tennessee requiring a 100% sample of encounter data.

That's basically a complete database of all encounters or, if you will, an encounter between a health care provider and a beneficiary. Those data will then be used by the states to produce their own measures, vis-a-vis, the plan submitting the HEDIS data. Encounter data will also be collected as a part of all the Medicaid choice demonstrations that are going on right now. It is a module in Medicare Transaction System (MTS). I don't know if you're familiar with that, but Medicaid basically had an A and a B contractor in every state. At one time there were 70 systems. By the end of 1997 or early 1998 Medicaid will be on MTS with one system nationwide and four processing sites. Encounter detail is a module right now in the MTS system.

Another example of our desire to work in a partnership is that we've been working on the Foundation for Accountability, which is a public, private partnership of purchasers and consumers. HCFA is a member of it, as are the Federal Employees Health Benefit Plans, the Department of Defense, AT&T, American Express, GTE, consumer groups, and organized labor. That group will attempt to develop new measures for value purchasing, which is the buzz word in HCFA in health plan accountability. It will also serve as a clearinghouse so people can make an informed choice.

In conclusion, I think it's fair to say that managed care is booming in Medicaid, and I don't think anything will stop the trend. Even in the southeast where we still have many states using the gatekeeper model, clearly every one of them is soliciting a managed care plan or an HMO. I think quality is emerging as a determining factor

in the survivability of managed care plans. Every one of our states has removed some from the program. Enhanced partnerships at the federal and state level and between public and private providers is imperative. The way that we, in managed care organizations, handle vulnerable populations will really be the deciding factor in the decline or fall of managed care in our programs.

Ms. Patricia MacTaggart: First, I'm going to tell you that for about a year-and-a-half I was a vice president of managed care at Delta Dental Plan of Minnesota. I reported directly to the senior vice president under actuarial services. I gained a huge respect for what you do. I also gained a huge respect of my lack of knowledge of what you do. Medicaid just had its birthday. It is now 31 years old. Now, as a state employee, I have gained an even bigger respect for what you do.

We, as a state, and other Medicaid agencies have moved from being the payor operating our own not very well operated preferred provider organization to really being a purchasing agency for other contractors for managed care. We have moved to a situation of not only needing you, but respecting how much you cost as we move forward. I hope I can give you a little basic information that not only will help you do your job a little better, but will result in a better value for what I get.

The basic fact on Medicaid is if you've seen one Medicaid program you have seen one Medicaid program. This does not make your life easier. Every state, because Medicaid is a federal/state partnership, has its own variations such as who's eligible, what benefits are provided, how payment is made, (Medicaid is probably not the best payor), and how we deliver health care services. The end result is, and this is my actual belief, Medicaid is not rocket science, but it's very complex and very expensive.

When I do purchasing, I purchase for over a half a million individual, publicly funded enrollees. When I spend money, I spend in billions. I jokingly say I truncate down to $100,000, but the reality is I'm a state bureaucrat, and you're my bosses. You won't allow me to truncate down to $100,000, so as your reality you may be contractors for us or contractors for our contractors. What's more important is you're taxpayers so you need to help us do this right, so that better quality comes out for the consumers that we're purchasing for so we better spend your money.

As Gene already said, we serve a variety of individuals. The numbers are the largest for children. We are about families and children, but the amount of money that goes to the elderly and the disabled is growing. Whether I like it or not, I'm a baby boomer. I am one of those groups, and we are getting older.

We are going to be the ones that impact the Medicaid program and the Medicare program, because one of the realities of Medicaid and Medicare for you and for legislators and all other constituents is you do not believe that you're going to be poor. You do not believe that you're going to be disabled. But you really hope you're going to be elderly, so we give much more attention to the elderly population, and if we are successful and do live longer we are going to cost money. As I pointed out, and so did Gene, the dollars are weighted more for the disabled and the elderly. Not only are the numbers growing, but the costs are also growing. Medicaid is the wraparound program for Medicaid for the low-income individuals. It is the wraparound program for institutional long-term care and acute care. That means we are a payor of nursing home care for anything more than an acute care stay.

Again, as we both indicated, the states vary by every option. It really does make a difference in what state you are and who is covered both at their income and their asset levels. It varies by what benefits. Some states have very condensed acute care services and some have very comprehensive services. Home and community-based waivered services or home care alternatives are the movement for every state. So it's not just about institutional care; it is also about the noninstitutional long-term chronic care. And how we deliver it, as Gene said, varies by state. Minnesota uses the comprehensive managed care model. Other states do carve outs.

When you're looking at numbers, you need to know what happened in the fee-for-service world that you are moving from in a state where you're looking at their numbers. You also need to know what they are really doing when they say managed care. It varies depending on whether it's a primary care model or a comprehensive or a carve out. All the risks and cost-shifting potential vary by what model is chosen, and how it's appropriately placed.

In addition, the disproportionate share of hospital payments vary by state. It's important to know where those dollars are, how it is actually used in the state in its fee-for-service model and how it was or was not transferred to its managed care model. Is there an expectation that those dollars actually flow to the hospital under a health plan contract? Is there an expectation that money is money in a capitation to be reutilized for other services where there are access problems like dental, immunizations, and home care alternatives? You need to figure out, when you're dealing with your contractors, how their hospitals in their contracts fit in the world of medical education and disproportionate share because the money they expect out of the rates is going to vary depending on how they fit in that scenario.

There are other rate issues. For Medicaid and children I think the most important thing to remember is most of the kids are healthy. So when you're looking at rates,

you see that they look very much like those in the employer market. I often sit down with health plans and point out that what we've purchased for Medicaid, we jointly purchase for our state employees. It has been an amazing experience. When we sat down in separate negotiations we heard different things. When it became one negotiation, the answers varied. Health plans finally figured out, although I would argue their actuaries knew all along, that we used individual rates for Medicaid in individual contracts, but for state employees, we used family rates. If you added our individuals together, you obtained better rates than you did with family rates because the history was very much the same. Again, even with family rates, you have to look back to what's in the fee-for-service cost and the rates that are established in the states. Some plan costs are lower payors than are others and that makes a difference in what's available in the capitation. We cannot spend more under capitation than we would have operating an appropriate mechanism under our fee-for-service.

The other rate issue that I would point out pertaining to Medicaid and children is that there are very expensive subgroups in children. Gene pointed out the AIDS population is a very expensive group. What you need to understand about Medicaid and children is that they come through the welfare door. They're from AFDC, and they have not applied for Social Security Income Supplement. Those children may go from very well to very sickly, but they have come in through the low-income door. We do want health care reform in states, but disabled children are not going to stick out as a separate category. They are going to be included in families and children. So when you rate, you need to look at the historical use of disabled children as a category of eligibility versus families and children because that will affect what is in the rate base and what you're expected to deliver in the way of health care. The contractor will be expected to provide every service appropriately needed by that child, and within those groups of kids, there are some very expensive subgroups.

In addition, you need to look at what is expected in the contracts that may or may not have been adequately addressed in the fee-for-service. The reason I moved to managed care is I expect an improvement in early and periodic screening. I expect all my kids to get immunized. In the world of fee-for-service, depending on your state, you see from 50% to maybe 75% or 90% of the kids under Medicaid actually immunized. I expect all my contractors to move to 90% or more on immunizations. If my fee-for-service base is at 50%, you should expect some adjustment in the rates to accommodate an increase in immunizations. However, in other areas I also think you have to look at the bigger picture. Many of our kids go to emergency rooms because they don't have medical homes. The emergency rooms are expensive. They end up in the hospital because they don't have a medical home, and they aren't getting preventative care. I'm not going to pay you

extra to get preventative care. I'm going to expect that you're going to reallocate those hospital dollars for your contractors to other mechanisms. So when you do rates you need to look at and work with your contractors if you're not on my side of the table. On the other side of the table you need to not only make sure I've adequately put dollars in, but that you've also worked out with the contractor what they can actually do to move the dollars around.

In the disabled population, the real rate issues have to do with where the money is when we moved to managed care because, believe me, there is a great deal of money in the disabled. We have not managed it very well. Sometimes, quite frankly, we have operated in a political system where hauling a group of very small children in wheelchairs into a legislative hearing at 11:00 at night often produces very large payments for very small subgroups of populations. The result of that is managed care does work, and if it's working well, there is a great deal of money in the world of disabled, but it means that the contractors have to know what they're doing. I think you also need to remember that we all talk about the disabled as one group but there are multiple groups within the disabled category. There are developmentally disabled and disabled individuals that need acute care just like you and me. They do not necessarily have large acute care costs, but they have huge long-term-care costs. When you try to put institutional care on the state side into a rate, you are talking about very big money. We need an accurate picture of what we need to put into the rates. You also need to know what needs to be in the rates. When you come to the brain injured, it varies across the board. There are some brain injuries that result in quadriplegia, with major physical disabilities, as well as more serious brain complications. There are other brain injured who strictly have a disability due to their brain injury. When you come to the issue of individuals who are disabled because of mental illness, you need to remember that they need a great deal of chronic mental health services. If they don't get those mental health services, they will use more physical health services. So this is where knowing where the carve-in and carve-outs are makes a huge difference in what the rates are. And then you have the physically disabled, which could be the asthmatic or diabetic, who are managed and not costly, or someone who is a cancer patient, who can be very costly. Again, in those areas it depends on how well the contractor manages.

When it comes to rate setting we must consider that we are moving into the long-term care area and we are talking about huge dollars, so we need to be very accurate. I can also say it's the newest area out there. So if you're looking for an area in which to specialize that needs a lot of help, this is the one for you. If you talk to your contractors, you'll find out it is not in their database. It is in the Medicaid database, it is in the Medicare database, but it is not in the commercial market's database. So developing rates, risk adjustment, and risk stratification

becomes very difficult unless you get each state's actual rate data. It is the future and it is where you need to pay attention.

The elderly category is not all that different from the disabled except that it is actually more predictable. Once you're elderly, you're at risk for needing chronic care if you're not getting chronic care already. So it is something that you are going to have in addition to any acute care needs. Once elderly people go on Medicaid or Medicare, they are on until they die, so we don't have the rolling on and off that you have with families and children.

The biggest issue with the elderly is the impact of Medicaid and Medicare. If you are working with a contractor who has only the Medicaid under a risk contract, they need to be worried about what is operating in that state on the Medicare side, particularly in acute care. Is there Medicare or fee-for-service? Is Medicare operated under a risk contract? Do their consumers choose a type of TEFRA risk contract? Depending on the state, different benefits are provided under the TEFRA risk contract. That impacts what decisions you make on the Medicaid side. There is a potential for fiscal cost shifts when they're separated. There's also the whole reality of some of the clinical decisions being difficult when you have separation of Medicare and Medicaid. What I will tell you from a state's perspective is that it is our biggest push to put Medicare and Medicaid together for the clinical benefit of the consumer. I'm also here to tell you that we're concerned about the budget; we do watch those dollars and we do watch how they're managed. Our biggest concern is the consumer and how we get the quality there.

If you have the Medicare contract and not the Medicaid contract, you have the same concerns in the reverse. It's probably harder to have Medicaid only though, because the acute care side, which is the first entry into the system, is managed on the Medicare side and all the wraparound alternatives to acute care services are funded under Medicaid. So the impacts of both of those and where a state is headed really do affect what you do in rates and rate setting.

One of the things I need to point out is Medicaid is a huge piece of health care reform. So is Medicare, but they are only a piece, and managed care is only a piece of the piece. It's a significant piece, but it's only part of the action. So by looking at only that won't tell you all the things you need to consider.

What's happening in the employed market in your area definitely affects what happens to your Medicaid and Medicare program. Federal and state approaches to the uninsured are important because you still have the uncompensated care if we don't deal with the issue of uninsured, and every state has a different approach to the uninsured. You need to look at where we're headed for long-term care. The

reality in Minnesota is even if the federal government never does anything in Medicaid, the state can't afford to not do something.

With our proposed increases, without any changes or any expansions in our programs for families and kids (and we intend to do expansions for families and children), we have, when combined with education, used up the entire growth portion and the budget for the taxpayers of the state of Minnesota. That leaves very little for criminal justice and nothing for anything else. In order to take care of criminal justice, we have to take something away from education. Believe me, that is neither popular nor the right direction because education is the future of our kids. So we need to sit down and find a better approach for our consumers. That means that we are going to look at alternative care services. We look at home care as an alternative to institutional care, and it does mean we look at the budget and the amount we pay. It means we look at value. When we make decisions, because we are a public entity, we are, in a sense, linked at the hip with the impacts of everything else.

The biggest issue we'll hear in 1996 coming out of states is the impact of welfare reform. There are many issues with welfare reform. Both the states and HCFA are now working through the issues. I can't give you the answers. One of the biggest issues is the decoupling of Medicaid from the new Welfare Reform Block Grant. States will have options to do some liberalization and cover more. States will have the option to do some cutbacks. I can't tell you what your state's going to do, but it will impact the uninsured, it will impact your rate, and it will impact the contracts going out. In addition, there's a reality that no state can do welfare reform without health care reform, so they have to look at health care reform and it will change. I hope it will change for the better.

Another large group concerned with welfare reform is the noncitizen. There's a whole new category called qualified aliens. I'm not going to go into those terms, but it may mean in your state a new area of uncompensated care. It may mean a new series of program changes. It certainly means new groups and new rules, and the impact of those are ones that you are going to have to consider in what you do. So looking again at history won't tell you too much about families and kids two years from now because the world will have changed on you, as will the marketplace. Again, in addition to the whole issue of welfare reform that happened there's a great deal of discussion of Medicaid reform. As I told you, even if Congress doesn't act, states have to act. We all hear, even in the political discussions, that we are the baby boomers. We are going to cost money. We have to look at the Medicaid program and that's a hard issue to address.

Last, but not least, because it's small but significant is the impact on public health. If all the health care dollars are used before we get to public health, that doesn't leave much for public health.

There is a need for overall community improvements in community health care. It doesn't do me any good as a purchaser to purchase something that's only short-term if I don't have the infrastructure over the long-term. All these issues are balancing acts. All these issues will be addressed differently in each state, but they will be addressed in every state.

What adds to the complexity is the fact we are in a very evolving market. In Medicaid, specifically, states have moved, as Gene said, from a payor to a purchaser. We have finally moved from programs to people. We should have done that a long time ago. We are really serious about quality improvement. In fee-for-service, I couldn't address anything but fraud and abuse. I can finally get to quality improvement, and I intend to. It means you and your contractors are going to have to validate performance. I need value, and the bottom line is nobody trusts anybody. You don't trust me, and I don't trust you. The consumers don't trust any of us and the legislators probably trust us even less. So if I can't prove I'm buying value I won't have that opportunity to continue buying value. If you can't prove that you can provide value for the money that you're requesting, you won't get the money that you request. This is all about performance measurement. There will be things in contracts now more than you've ever seen before that have incentives and penalties specific to behavior. So know what your contractors really can do versus what they say they do and how that affects the rates that they can live with. This is something imperative to doing the right kind of rate setting. You need to know what's happening in the fee-for-service world that you're going into and what's in the base of the rates because most states are still using their fee-for-service history as a base for their rates. You need to know what's expected, what's changing in the Medicaid program, and then you must make sure that what is required in the contract appropriately matches what's in the rates. If you're ever really happy with what I put in the rates, I know I've put in too much, so that's the reality check. Somewhere along the way, we come to a middle ground.

In this process of quality improvement we really do believe we are looking to innovation and not structural regulation. That does not mean the state or the federal government will not do oversight, but we will give the contractors flexibility to do things differently and better. If the outcome is not an improvement we will step in. Those contracts will be written to have those penalties and disincentives. What's most important is the lesson that we've learned that we are about care delivery systems, not about a la carte health care. That is the biggest change that you have seen and will continue to see.

The acute care, which is the families and kids on the AFDC, represents the small dollars. It builds when we look at the acute care for all the rest of the populations. But what gets bigger in the pyramid is when you add the long-term care, and the biggest pyramid, is one that we will deal with incrementally. It is not going to happen in a fast track and that's overall national health care reform. So in the meantime, we have to deal with all the pyramids that have built up to that larger pyramid, and we do that with other constantly changing challenges.

As Gene already said, the biggest three things that I am required to do as a purchaser is deal with access, accountability, and affordability. With access I expect my contractors not only to have a network available when my consumer needs it, but also to get my consumer into that network and into preventative care. So when you're looking at rates, you need to really have serious conversations with the contractor about what they intend to do to improve access, and there is an access variable in all kinds of rates. Accountability is here to stay at the provider level, the contractor level, the state level, and the consumer level. In Medicaid, with the limitations on copayments we have to look at different ways of reaching accountability, and the bottom line is affordability. I have always said, if you give me an extra $4–5 billion, I can have all the access and accountability in the world. But if you expect me to do it with the same amount of money or less, it makes the other two much more difficult. Unfortunately, there is no state that has an extra $1 billion, let alone $4 or $5 billion.

The hard problem is the difference between current resources and reality; it's what I call the gap between reality and expectations. Advocates and consumers think we have figured this all out and can do it and have been able to do it for five years, but we just don't want to do it. In reality most of them acknowledge the improvements in technology and acknowledge the importance of information systems, but we don't have them and they are very expensive to produce. Unfortunately, we have to have them, and we have to spend the money.

The reality is I've been running a Medicaid program for over 20 years. In those 20 years, there were basic questions that I have never been able to answer. I am the best payor of bills, and I probably operate one of the better preferred provider payment systems. We really do have diagnostic related group for hospitals, and we really do have prior authorization. I just can't do it as well as a contractor can do it for me. Now with that caveat aside, there are real basic questions about value that I have never been able to answer. What we need to do is obtain that information from our contractors. What's more important, from your perspective, if you're on the contractor side, is if you can't use or obtain quickly information on who's enrolled or what kind of management there is, you can't manage within the dollars available and your contractors will go under. So I truly believe if you don't have

the information, even if you haven't given it to me, you can't be managing. So I expect that you have the information, and I expect that you can give it to me.

That brings us to comparability measurements in management. The only thing that will work is we get to comparability. The only way we won't spend a fortune is if we all look at data and information the same way. Even then we will spend a small fortune. Gene said the most important thing out there right now in discussions is the NCQA and HEDIS. If you do not know what HEDIS 3.0 is, and if you have not seen it, have somebody on your staff spend the time to learn. It is the acronym that is out there. It is the future. It is what you will be held accountable for. If you don't know the numerators and the denominators and you don't know the impact you won't be able to tell when it comes to incentives and penalties, what is in the rates and what isn't. But it is the future; it is what states are moving to for Medicaid. It's where Medicare is headed. It is where the private sector is. For once private purchasers and the public are trying to do it the same way to make life easier. We also make the data comparable when we're done. That is a change. It also means we're all in transition. The next 18 months or two to three years, when it comes to performance measurement, are going to be in a turmoil, but it will get us to where we need to be. We don't have the time to wait, so you're going to have to perform some surgery and go through a little bit of turmoil.

The last issue is provider payment, which means not only risk adjustment, but risk stratification. It's crucial, particularly for the disabled. It's what we all need to do. There are only a couple of experts in the nation. This is the area where we expect actuaries to come up with the answers because we really need those answers.

Here is what you can expect states to do. You can expect them to walk away from fee-for-service and move to capitation. That does not mean we expect our contractors to pay every provider on capitation. Many of them will operate a modified fee-for-service system, but we will have to, for budgetary reasons and adequate risk management, look to a capitation reimbursement system. You can expect us to deal with the effects of welfare reform from the decoupling of health care to welfare, to Medicaid eligibility expansions or limitations depending on the state and the whole issue of the immigrants, the undocumented citizens, and so on.

We have the ability and the opportunity to change the world that no one ahead or immediately following us will ever have the opportunity to do. We can either do it well together for our future, as well as our kids, or we can blow it. It's really all in our hands, and I hope you see that; opportunity is really here.

From the Floor: My question is regarding the various states where the Medicaid recipients are being put into managed care. Are they the same managed care plans

that nonMedicaid persons use? If so, is the quality of care the same for both the Medicaid recipients and the non-Medicaid recipients, or do we have a two-tier health care system?

Ms. MacTaggart: What I can tell you about Minnesota is that we truly believe in portability and giving consumers the ability to be with the same contractor. So our goal is always to contract with the same plans as the private market. The ultimate goal is you have the same contractors for Medicaid, private, and Medicare, so they don't have to change their networks when they go from young to old. What I will also tell you is that we have more quality improvement and consumer protection under the Medicaid side than there is in the Medicare risk contracts. So even though they're the same contractors, they are actually held to an even higher standard on the Medicaid side. We do not allow any direct marketing, for example, under the Medicaid side. It is allowed in Medicare. Now there are reasons for that because the Medicare population outside the dual eligibles is a much different population. But for consumer protections for the population that I serve, we contract with the same entities. We have additional consumer protections. The third piece that's important is it's also the ones that they had the opportunity to be in when they were in the employed market.

What I will tell you is interesting, because I think it is a difference of our ages and the marketplace changing. I've grown up under managed care as a state employee, as a county employee, and in the private market. The only health care coverage available to me for my entire career has been managed care plans. My parents' generation did not have that. They lived in a fee-for-service world, so their view of Medicare has been more of a fee-for-service. However, at their age, the last thing they want in crisis is more paper and more kinds of stuff. We had one legislative hearing that was filled with elderly individuals on Medicaid. They came in because the Medicare risk contractors were leaving Minnesota because of Medicare's rates. They wanted our legislature to do something because they've always been connected with those, and they didn't want to lose them. I don't think you'd find that happening now in many states, but I think in five years you will because people will want the continuity of their program to continue. So we're in an evolving market. Depending on the state, I think you'd get different answers, but I think there's probably more protections in Medicaid than in Medicare.

Mr. Grasser: She's exactly right on the protection. In the southeast, and I guess nationally, Medicare is about 10% managed care. As I said, Medicaid's probably 32% managed care. It probably would be way over 40% this year. One of the problems she alluded to is marketing abuse. Florida learned a nice lesson from the school of public humiliation last year because of some newspaper articles. The lady who wrote them was a Pulitzer runner-up from the Lauderdale *Sun Sentinel.*

Florida had put in marketing controls, and we find that Georgia has marketing controls. Basically you're allowed to generically advertise. You're not allowed to go door-to-door or to go to any of the beneficiaries or, in fact, write to any of the lists.

Unlike Trish who grew up in a managed care environment, I grew up in New Orleans and I now live in Atlanta. Atlanta has a great deal of managed care as does Florida. In most of the southeast, it's a four-letter word and there really hasn't been the mix of the same plan but there should be. Obviously, the Medicare market is a little different than a commercial plan because it doesn't cover all the services that would be in a commercial plan. As Trish pointed out, Medicaid states like Tennessee have a terrible time where they're doing the wraparound and can't control access to the system. We all know the access comes through the physician. So there hasn't been much of that. The Oregon waiver, when it went to the elderly and disabled populations, required that they be consistent providers of managed care. They should be. I think Trish is right. It's evolving, but in our states, for example, Mississippi is moving into managed care.

I know they're soliciting HMOs. They have a major primary care case management system. There's not a Medicare enrollee in managed care in the state of Mississippi and there's none in Alabama to speak of. I think that's where we should go. The gentleman is clearly right. We should have people in the same plan. It's the only way it's going to work, but it's not here now.

Mr. Roberts: I have observed that there's a big variation by state from what I've seen in terms of whether the Medicaid beneficiaries are tending to enroll in health plans that also serve the commercial population versus emerging health plans that have started solely to serve the Medicaid population.

I know that, in particular, Connecticut, New York, and Pennsylvania have a large share of the Medicaid population enrolled in specialty health plans, so I don't know where that's going, and it definitely varies geographically.

Mr. Grasser: There is some history behind that. There were apparently some terrible Medicaid abuses in California in the early 1970s and there's a law on the books called composition of enrollment. A plan can get a three-year waiver, but within three years, they must have 25% non-Medicaid and Medicare commercial enrollees. There are similar provisions in Medicare and all of that gets back to, as Trish pointed out earlier, the lack of quality measures. There was no quality measure then, so as a proxy, they established this composition of enrollment. As we get quality measures we would prefer that one plan would do the entire population. For example, in Florida we have one very good plan now that hasn't

met that, and we would hate to lose them because they seem to score well in every quality measure the state has. So I think it's a question of becoming a little more sophisticated and, also, the amount of commercial type plans that would take Medicaid would depend, as Trish said, on the rates. Our only requirement is that it can't exceed fee-for-service, so obviously if you're starting in Mississippi or Alabama that rate is probably going to be considerably lower per eligible person than it would be in Georgia, North Carolina, or Florida.

Mr. Carl D. Smith: There is one thing that I've seen in the last few years with some states in the rush to get managed care under Medicaid. Physician groups spontaneously come together to accept risk under Medicaid contracts. In my mind, that creates concern over solvency because some of these are not very well formed and thought out in advance. They make up their operating procedures as they go along. What are the federal and state concerns that you have in terms of solvency issues, and what types of things are you looking at as a means of guaranteeing or at least enhancing the solvency level of some of these plans?

Ms. MacTaggart: You hit one of the biggest issues states are seeing, first, because they're in transition and, second, because there is almost a backlash to managed care right now. There are many physicians who are trying to organize themselves. We have county governments trying to organize themselves. There are many people who believe that there isn't a benefit of the administrative overlay of health plans. Believe it or not, I am not bought and paid by health plans, but I truly do believe they provide a service. And what physicians and other groups haven't figured out is those information systems cost money. The ability to do quality measurement and quality management costs money. Solvency is imperative.

In the State of Minnesota, we don't like to contract with anybody who's not a licensed health plan or a community integrated service delivery network. This is a term used only in Minnesota that allows you to be a small health plan, but you have to be an integrated service delivery network. We do have a regulatory department of health overlay for both the commercial side and the public side that diminishes some of those concerns about solvencies. I have contracted with a preferred provider organization that wanted to become a health plan in 1985. We mutually agreed that this was not a good idea for them. The plan was losing its shirt.

I have to be very concerned about physician behavior when one of the things we spend a great deal of time on in federal regulations is the payment structures and the actual risk physicians take on. One thing you don't want them to do is spend all their capitation the first month and then not provide services. There is not a true understanding of the financial responsibilities that go with that or assuring solvency. If people are well the first three months, you'll look like you're making a great deal

of money. It's that first heart patient that you'll have that will blow the entire capitation. So part of this is a learning tool. It also is an acknowledgment to you that we have many states that are in transition and going from payor to purchaser. We are trying to do very well. We are going to make mistakes. Even Minnesota makes mistakes, and we've been doing it for over 20 years. We, hopefully, don't make big mistakes that hurt consumers.

One of the things that I will acknowledge to you is we don't have actuaries on staff. I tried for three years, and I found out the only thing I can afford is to do very good contracts that pay you fairly well to get your business. I need to have that kind of knowledge base, because my contractors also have it. Many of the physician groups don't have that knowledge base and we both end up picking up the pieces. We learned the hard way about the importance of having an actuary. State staff in other states don't have actuaries either. They are figuring out that they need contracts. The same thing happens with my staff who were payor staff. They are not well suited to be in a purchaser staff, so we have to do some education and training. We need to look out for these issues, but solvency is a difficult one. It's going to vary by state because it depends on your regulatory overlay and what's in your contracts. It's also the issue that's going to hit the front page if we don't deal with it.

Mr. Grasser: When Tennessee is in your region you've seen everything. We had many problems with solvency. There were groups that merged overnight and, suddenly had 100,000 enrollees. As I've said, they did a lot of auditing in that area. The state controller is very active, but they had to spend a great deal of time in the incurred-but-unreported areas and denied claims. Some of them were basically making advance payments before they could get their systems up. Things like incurred-but-unreported are really not audit issues. It's not something a typical auditor deals with or is experienced in.

There's a new player that we see in most of the managed care plans. That's the Department of Insurance. They were never a player in Medicaid. We used to deal with eligibility groups and health departments, and most of them were well meaning. Florida had many problems with that. For years public hospitals and federally qualified health centers have tried to back into the managed care business to keep their market share. The problem with that is they didn't meet the criteria of the Department of Insurance. They couldn't maintain reserves. You know they were not publicly traded entities. Much of that has changed. You can't, for example, enter into the contract anymore in this state unless you meet all of the Department of Insurance requirements. There are no more Medicaid plans that couldn't sell to a commercial person. Again, as Trish said, data are key. I think

probably the saving grace is that most of them in most areas were paid 95% as fee-for-service, and it's hard to go broke on that. Clearly, that wasn't the answer, but that may have kept us out of the solvency battles.

Trish is right; everybody needs actuarial support. In an area like Tennessee where they weren't as generous with the rates, that was the one big fear, and probably the only thing that could bring that place down would be a major collapse of a managed care organization.

From the Floor: If I could just follow up with one thing that perhaps you're not aware of. Regulating the plans is good, and I think insurance commissioners, by and large, handle that well. But what's going on behind the scenes is something called downstream risk where the health plans are passing full risk down to provider groups in some situations. Is there anything in the works to deal with that issue?

Ms. MacTaggart: Yes, there are the federal regulations.

Mr. Grasser: The National Association of Insurance Commissioners (NAIC) is dealing with it.

Ms. MacTaggart: What I could tell you is it's one of the things that our regulatory agency, not the purchaser, is looking at very closely, because it is a huge concern. Where is the capitation, where is the risk, and where is the behavior? You want to influence physicians, dentists, and everybody's behavior, but you don't want it too close. As that risk moves down, it becomes, in some cases, too close to the behavior. You're absolutely right. The other thing that I can tell you is the states that have less regulatory overlay will have Medicaid only plans. You have to look at that even more closely, because in some of the insurance and regulatory agencies, they do have provisions that deal with that. Other states don't.

Mr. Grasser: Now there are some requirements on the Medicare side to find out precisely how they reward their physicians. I know that's been a big issue, and I think there will be much more public scrutiny over exactly how the physician incentives are structured. I know that has been one of the issues. But that's been a big problem. It was, again, a problem in Tennessee when they set capitations. The rates weren't the same. They weren't adequate in some cases. As Trish said, you can't simply assume all are the same. For some, it was a great rate. For others it was awesome, but that is a problem. You're right, they do push it down. I think we're beginning to see more and more control over that. As the Medicare plans are evaluated, it's one of the issues they look at.

Ms. MacTaggart: This is where you need to look at HEDIS 3.0. It was a big enough issue for Medicaid, Medicare, and the private market, but as a physician, it's going to be even more important because we all want that there.

Mr. Kerry A. Krantz: Our state Senate has passed a bill asking the department to try to determine appropriate loss ratios. I'm not even sure that regulating loss ratios is an important thing. I think what they're interested in probably is ratios of benefits to total expenditures. I have no experience in this field, but as the valuation actuary and the person who's being asked to help out, I'm wondering what kind of assistance I can get. The bill actually says that we are to try to consult with academics, with consulting actuaries, and others who have experience in the field. We must also deal with our agency for health care, which I haven't begun yet because I've just recently started to research the issue. Who are the people who are the experts in the availability of data in this area?

Mr. Grasser: I really wasn't aware of that. I'm too busy with your bill to close the ICFMRs this year and the bill to bid the HMOs. I don't really know who in HCFA would have that. I would suggest you contact the reporting agency in every state. It could probably give you some idea of what they're seeing. You may want to call the state controller's office in Tennessee. I guess they'd probably pay the lowest rates, so we may see what their loss ratios are. The people in this session would be the best people for you to contact. Trish, do you have any group that looks at that?

Ms. MacTaggart: NAIC might not be a bad place to start. It has done some work in that area and I can give you a name there. The problem is what you identified upfront. What did they mean when they said that there are four different answers, depending on what they really were looking for?

Mr. Grasser: And do they want high loss ratios? I mean what are they looking for?

Mr. Roberts: Trish, you explained to the various dollar magnitudes of the programs out there. The long-term care piece was somewhat overwhelming. On the acute care side the lowest unit cost population is AFDC. This sector has been well developed because of the strong parallels with the commercial managed care industry. The long-term-care industry does not have the same care management processes developed, and my observation on the acute care side is that there are clearly identified places to get savings by delivering care in the most efficient setting. Long-term care is a little different in its dynamics, and I guess I'm curious whether anybody has any vision on where savings can be achieved in long-term care.

Ms. MacTaggart: Gene and I have the same answer: community alternatives to actual institutional placement. Under federal law, it means having to prove adequate payment, etc. It requires that you do an automatic increase every year to institutional facilities. None of us want to be in institutions. So part of the goal of managed care is to keep people out. Right now, if a quadriplegic doesn't get turned he or she gets bed sores. We put them in a hospital. We take care of them. If they are turned and have proper care at home, they don't end up in the hospital. There is more savings in the chronic care area than in any other because if chronic care is managed, it can be managed well. Even high-cost cases are cheaper when they're managed well.

The other thing that I would say is that alternative services are very important. You look at the whole person. Many times, fee-for-service is a la carte. We don't look at substance abuse. We don't look at mental health, so the physical health costs get huge. You should deal with those issues. They're actually fairly cheap. One of our health plans pointed out to me that the reason the chiropractic issue went away is they sat down with their doctors and did their own study of chiropractic care. Even if patients go more times than is needed, chiropractic care is very cheap care. It gets them back to work right away, and it actually takes care of their physical needs, so they don't show up in the doctor's office, which is more expensive. Rehabilitation services turn out to be much more expensive. Looking at the total person and giving care immediately rather than pushing it off is where the savings are. But what I will acknowledge to you is nobody spent much time on the actuarial side working these things out, and there is a huge amount of money to be saved, so we need to make this an emphasis.

Mr. Grasser: We've pointed out that, across the community, Medicaid will pay for community services, which are basically socialism in some ways. Examples are people coming into the home to help them get their food, get dressed, or whatever. Of course, there are the home health benefits, but the idea would be to keep them in the community as long as possible.

I think on the ICFMR side, for the developmentally disabled, there are only three or four states that have built any homes in the last eight years. The goal was to move people to the community. On top of the fact that it's more reasonable, it's more humane. But it really hasn't been an area with much interest. North Carolina is now providing personal care services in group homes for the elderly and in domiciliary care. Before, if you really didn't have a home environment, you went into a nursing home. If you're by yourself and you live in some sort of a group home or domiciliary care unit, they will come in and treat you there as opposed to committing you to long-term care in a nursing home, because simply there was no one, if you will, in the home to provide the care or to coordinate it. I think that’s

clearly a savings. Every state that has racheted the budget down realizes they must deal with long-term care. It's just outrageously expensive.

From the Floor: I have a suggestion for the rapidly rising costs of long-term care and I approach it from the other side—the financial side. There's just too much that goes on despite the provisions against transferring assets and so forth. There are too many legal loopholes where assets are transferred and the taxpayers pay the cost so that the kids can get inheritances. I think there could be much more tightening up as well as probably more enforcement.

Mr. Roberts: I think there's another regulatory issue if the goal is to move out of institutional care into other forms. Most of the other forms available outside of the nursing home are not regulated or available in many states. Intermediate care facilities, assisted living facilities, and I think home health is reasonably well regulated. If there's a goal to maintain some form of quality, then I think the regulators need to step up and find ways to manage and assure quality at some of the other facility types, or we'll have an even bigger mess than we have now.

Ms. MacTaggart: I wouldn't disagree, but I would say there are other ways than strict regulation. I can write requirements in a contract in a care delivery system that I have concerns about. I don't need to write that regulation into everybody's contract; it depends on who they have in a network and what they do. I wouldn't want to overlay the assumption that we want to add a great deal of regulation. There is a level that is required, but after that this is a new world of contracts. We need to pay close attention to what's in a contract, and we must do better at writing them.

Mr. Grasser: I think one of the demonstrations is this area called Care. Florida is developing one. They will pay a home and community-based provider a fee, that could carry the person all the way through long-term care. There'll be a slight wait for long-term care, but it will be mostly based on the community. So one provider will have the incentive to take that person all the way through and to keep him or her in community care. That's one very small model. There were two different providers and, of course, there has always been the debate of who ends up in a nursing home and who doesn't.

Ms. Kristi L. Casey: I was always very interested in the organ allocation method, and I would like to hear some comments about your opinion on that.

Ms. MacTaggart: We've always found it fascinating. The truth of the matter is up until now we really have not had to cut off anything significant, so there has been a very intelligent debate as to what's an appropriate service. Where it will become

hard is when they come into budget issues where something will actually have to be cut off. I don't think we've really seen the impact of that because, almost across the board, they've had enough dollars to really cover everything everybody thought was appropriate. The honest answer is Oregon was just more upfront about it. Every state is having the same discussion, but the difference is it hasn't been necessarily as public because it is all about rationing. We either cut people off entirely and they don't get any benefits, or we look at different benefit packages and cut some of the benefits. What Minnesota and most states are trying to do is find a better way of delivering care that allows alternative services rather than actually having to cut out benefits. To me, if you don't deal with it through service delivery, you're forced to deal with eligibility in benefit packages. I would just prefer to do it through the service delivery and to do appropriate care rather than having to cut out people or an actual benefit. The same discussion is going on. It just depends how far we get through the current mechanisms so we can avoid having to actually cut that off.

Mr. Grasser: Every state goes through the debate on the various organ transfers and whatever. But Trish is right; that debate clearly goes on and that was the debate, if you will, in the health care reform proposals. Some people get the complete package and others don't. Some states have tried to modify that in places like Tennessee. Frankly, I loved it. It took some of the heat off Tennessee for a while. I think Trish is also right about how you can look at the numbers, and you can look at the national debate, and you can look at the size of the growth of HCFA. We're not going to continue to get a peace dividend forever. I think we've spent that, and rationing is going to go on no matter what you want to call it, whether it's by people or by benefits. Tennessee's leading advocate, who has sued them more than probably the other eight states in the southeast, loves Tenn Care because his theory was, and I'm not sure the state subscribes to it, that there are only two ways to go—side with providers or side with people. By lowering rates and covering the uninsured, the advocates in Tennessee felt they sided with people. There is a debate everywhere. As Trish said, they just were more public about it.