[BRIEFING]

The Committee on Health and Human Services met at 9 a.m. on Tuesday, November 27, 2012, for the purpose of a briefing on the federal Health Care Act and Medicaid. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; and Gwen Howard. Senators absent: Bob Krist and R. Paul Lambert. [BRIEFING]

SENATOR CAMPBELL: I want to welcome you to the public briefings this morning sponsored by the Health and Human Services Committee. And, while this is an educational briefing, I will go through a few rules. And the first one, of course...everybody has got their cell phones out; thank you very much. Make sure that they are silenced or turned off. It's very distracting to hear them and embarrassing for you. (Laughter) So we always put that reminder in. There will be no public testimony this morning. There is a briefing, education meant to give background on the Affordable Care Act; as well as Director Chaumont will be joining us later in the morning to give her, what I call, Medicaid 101, which she has done for the Health Committee. And I always find it very helpful to start with the fundamentals, and I appreciate her willingness to give that educational briefing today. We will be taking just a short break, and I would appreciate it if you all just stay in your seats after Joy's presentation and questions by the Health Committee. But we will have cards available for senators or staff people. If you have a question, you can jot down your question. And I will read the question, and Joy has promised to answer every single question on any topic that anyone may ask. So, in any case...(laughter). [BRIEFING]

SENATOR COOK: Yea, Joy. [BRIEFING]

SENATOR CAMPBELL: There are really far too many of my colleagues in the audience to introduce all of them. I want to thank them for coming and also to particularly have a special welcome to all the senators-elect. We appreciate, we know you have a lot of

orientation meetings and one extra. So thank you to all my colleagues who are here today. As is our custom on the Health Committee, we will introduce ourselves, and I'll start at my far right. [BRIEFING]

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, northeast Nebraska. [BRIEFING]

SENATOR COOK: I'm Tanya Cook, District 13, in northeast Omaha and Douglas County. [BRIEFING]

SENATOR GLOOR: Mike Gloor, District 35, which is most of Grand Island. [BRIEFING]

SENATOR CAMPBELL: Kathy Campbell, District 25, east Lincoln and Lancaster County. [BRIEFING]

MICHELLE CHAFFEE: I'm Michelle Chaffee; I'm the legal counsel for the Health and Human Services Committee. [BRIEFING]

SENATOR HOWARD: Gwen Howard, District 9, which is really the heart of Omaha. [BRIEFING]

DIANE JOHNSON: And I'm Diane Johnson, the committee clerk. [BRIEFING]

SENATOR CAMPBELL: Diane will be roaming around today. She's going to start the recording and then do some checking on some other things. So if she gets up and moves around, don't be disconcerted by that at all. It is certainly a pleasure and we appreciate so much that Joy Wilson has joined us from NCSL. For the senators, NCSL is probably one of the most top-of-our-list sites and places for us to check for information or to call. And so we are particularly pleased to have Joy. When we decided to plan this briefing, we waited purposely until after the election to sort of know what

paths the Affordable Care Act might take. We also would know the composition of the U.S. Congress; we'd know the composition of the Legislature and could have our new members with us. And then it fit with Joy's schedule. So that was extremely important. So today I introduce Joy Wilson, who serves as the health policy director for NCSL. So, Joy, it's all yours. [BRIEFING]

JOY WILSON: Thank you. Is this on? [BRIEFING]

DIANE JOHNSON: It should be. [BRIEFING]

JOY WILSON: Okay. It's a pleasure to be here, Madam Chairman and members of the committee and members of the Legislature who are in the audience. I always enjoy coming to Lincoln; your Capitol is distinctive. What I thought I'd do is start out with a little bit of history about Medicaid because I think it provides the context by which Medicaid was addressed in the Affordable Care Act and somewhat explains the notion of the expansion. So it was enacted...Medicaid was enacted along with Medicare in 1965. It was primarily a program for women and their dependent children and seniors and people with disabilities. That's kind of where it started. There was a distinct connection between the Aid for Families with Dependent Children and the Medicaid program, which made Medicaid a connected piece to welfare. And that's very important. So that if a woman and her children were receiving cash assistance through AFDC, then they automatically were eligible for Medicaid. So they were attached. In 1996, the welfare reform law changed that connection. It severed the connection between cash assistance and the Medicaid program. It changed the name from Aid to Families with Dependent Children to Temporary Assistance for Needy Families, suggesting a change in concept. And an effort was therefore moving forward to make Medicaid an insurance program as opposed to a welfare program. It was going to take a lot of more activity for that really to happen, but that was the notion of changing the name, changing the concept. And then in the Balanced Budget Act of 1997 the next year, the Congress enacted the State Children's Health Insurance Program, which was a program to cover

children and families with incomes up to 200 percent of poverty, stretching the notion of a public insurance program for low-income people. And with the CHIP program, there was a concerted effort on the part of states to separate it from Medicaid by giving it a different name and making sure that the card looked more like an insurance card as opposed to the identification cards that Medicaid recipients received. Now, both Medicaid and CHIP were voluntary programs when they were enacted. No state had to join the Medicaid program. And, in fact, Arizona was the last state to go into Medicaid. And I forgot what year it was, but it was several years after enactment. And when they came into Medicaid, they are the only state where their entire Medicaid program is an 1115 waiver. So that sets them apart from everybody else. CHIP has been reauthorized twice since its initial enactment, first in 2009. And for those of you who were around, it was left unauthorized for quite a bit of time and caused a lot of consternation at the state level because we weren't sure whether the funds were going to come forward, and we had people on the program. But they finally did get it together, my friends and colleagues on the Hill. And in 2009 it was reauthorized through 2013. In the Affordable Care Act there was a major change in CHIP. CHIP became a nonvoluntary program. It became a grant condition of participating in Medicaid, which is very different. It remains a block grant. And they extended CHIP through 2019. They extended the authorization until 2015, which means in 2015 there will have to be a discussion about what happens with the CHIP program within the framework of the Affordable Care Act. You are all familiar with the "maintenance of effort" provision, which was a part of the Affordable Care Act, which does not allow a state to change anything related to eligibility up until 2014, when the health insurance exchanges take place. For Medicaid, the maintenance of effort for CHIP runs through 2019, which, people note, is past its authorization date. So I cannot explain that, I can only say it exists. And then, of course, in 2012 we had the court decision, which changed everything about the Affordable Care Act and, in particular, the Medicaid expansion. I actually stood in line two different days to get into the Supreme Court to watch the decision. And it was interesting because the Chief Justice, who read the decision, knew he was going to do something fun, because he just had that smile. He was smiling and he was reading. And he started off with the

individual mandate, and he went on and on about how the commerce clause did not save the individual mandate. Now, when you're sitting in the audience, you're barely allowed to breathe. If you say anything, they have armed people who will take you out. So everybody is sitting there being very quite and thinking, okay, the individual mandate is going down. Well, the press have their own little area where they're allowed to go and talk to their colleagues so that they can report. So I think it was CNN and Fox, if I am correct, left in the middle of him reading his piece on the individual mandate and reported that the individual mandate was gone. But he paused after he went through his commerce clause discussion and said, "But," and then went on to explain how the majority of the court had decided that the individual mandate was upheld. And you could hear...all you could hear was breathing (laughter). Everybody is looking around, but then he goes on and talks about other things. Then he gets to Medicaid, and we're like, oh, what is he going to say about Medicaid? Nobody had really given much thought to Medicaid because only one of the appellate courts had even addressed it, and that one court said that the expansion was unconstitutional. But no one else even bothered to consider the issue. So when the Justice said, you know, we're not upholding that Medicaid expansion; we find that that's...it was not...he basically said that this is really not part of the existing program, this is a whole different piece, and that because of that he thought it fit into the framework of an unconstitutional intrusion on the states. Now, he really kept his comments to the new adult population. And so the read has been, and most people believe, that the only piece of the Medicaid expansion, which involves a lot of things, is the new mandatory coverage for able-bodied, nonpregnant single adults with incomes below 133 percent of poverty. Now, not everybody agrees with that reading, but no one has challenged it in the courts so far. So that is what everybody is working with right now. And so basically what he said was that a state could do that if they wanted to, but they cannot be penalized financially if they choose not to expand to this new population. So under the Medicaid expansion provisions in the Affordable Care Act, it establishes a new minimum eligibility requirement. So this is a national eligibility floor, and it's 130 percent of the federal poverty level. It also requires that a 5 percent income disregard be applied, which makes the effective minimum rate 138 percent of

the federal poverty level. It eliminates the use of income disregards by states. So a number of states--and this is important--were able to cover people with higher incomes in Medicaid by disregarding transportation costs to work, day-care costs, other costs that a state might identify, so that that would not count towards their income. So this new income floor for some states actually made it lower than what they were doing with income disregards. So this was an important change for states. It also eliminates the assets test for most individuals. It added new mandatory categories. So we know about the adults; it added parents and former foster care children under age 26. And some people could not quite understand how that provision came in, but this was to give parity to foster children who don't have parents, where the state was the parent for them. Where under the Affordable Care Act it does allow parents that have insurance to cover their children up to age 26. So this becomes effective in 2014 and was another expansion. And that is not impacted at all by the Supreme Court decision that goes forward, as a mandatory expansion. It also changes the methodology for determining income to something called MAGI, the modified adjusted gross income. Now, the interesting thing is that this brings the IRS into the Medicaid arena. And if you've ever been on a conference call, like I have, with people from the IRS and people from Medicaid, it's really like people talking foreign languages at each other (laughter), and you're watching. So this has been kind of a difficult piece of moving forward on the Affordable Care Act, in that the IRS is the entity that imposes the penalty for the individual mandate. So if you don't get coverage, it's the IRS that imposes the penalty. And so it is also the IRS that...the MAGI is really an IRS concept. Adjusted gross income is an IRS concept, not a Medicaid concept. We in Medicaid have done eligibility totally different. And so the definition of a family, IRS-style, is different than the definition of a family Medicaid-style. So in the exchange, which we're not really talking about today, we're mixing Medicaid style and IRS style on eligibility, which has been fascinating and is an ongoing effort to make that happen. So that it matters how IRS thinks the family is constituted when it comes to doing eligibility for the exchange, and it affects Medicaid as well. And I'm sure your Medicaid director could have stories to tell about that. It also provides for an enhanced match for newly eligibles. And it's important.

The enhanced match is not for everyone new who comes on to Medicaid; it's only for people who were not previously eligible for Medicaid. So if they were eligible but not enrolled, they do not get the...the enhanced match does not apply to them. So this is the schedule for the enhanced federal match. It is important to note that the amount of the enhanced match is statutory. So it's 100 percent for 2014, 2015, 2016. It's in the statute. And that becomes important when we talk about alternatives to the current concept. And this is the definition of "newly eligible." They're making it clear if somebody had been eligible and just had not signed up, they don't count for this enhanced match. And that becomes important when you calculate the cost of the Medicaid expansion for your state. I have a slide talking about MAGI. The exceptions are important. It's important for the exchanges because they have to figure out how to do the eligibility both MAGI style and Medicaid style, because if you get on Medicaid because of being eligible for another federal program, MAGI does not apply to you, and you use whatever eligibility got you into the Medicaid program. So if you're a foster child, they're not using MAGI; you are categorically eligible for Medicaid, and that's how you get there. If you're on SSI, you are categorically eligible for Medicaid, and that's how you get there. So in the exchange they will be running the IRS eligibility, the MAGI, as well as the regular eligibility for other federal programs. So I just thought that was important. And there is a transition for people who were in Medicaid, they're already in Medicaid on January 1, 2014, when the exchanges come into place. And there's a transition period to...where they're not reassessed until their redetermination date comes by. And then they would be...then MAGI would be applied to those who are not on some other federal program. So the game changer, why the decision is so important, is there is no penalty, there is no deadline, and HHS has said states can go in and out of the expansion at will. So you could put your toe in the water, you can sign the papers, you can do it for a year at 100 percent, and go, you know, I'm scared, and get out, which was not the plan that Congress had put in place. So if a state decides not to implement the Medicaid expansion, individuals with income above 100 percent of the federal poverty level can go into the exchange. Nobody ever planned for this to occur because they would have been in Medicaid mandatorilly. So this is kind of...you come to this by looking at all the

various statutes and figuring out that they had not thought about this, and so this is how it is. So if you are over 100 percent of poverty, you can go into the exchange. If you are below 100 percent of poverty, you're not eligible for Medicaid; you really don't have a home. So these are the gap people, because there is the...under the original plan they would have been covered; under the revised plan per the Supreme Court decision, they are left without coverage. Now, originally people were concerned about, would they then be subject to the non-coverage penalty under the individual mandate provisions? But the statute provides two exceptions. One is the income exception. If the premium would be over 9.5 percent of your income, you would not be penalized. It also provides a very broad and sweeping provision for the Secretary to make exceptions as she finds necessary. So in a letter to the governors in July, she stated that she felt that most people who would fall into this gap category would fall under the "premium being higher than their income" exception. And she said, for the small number of people where that exception wouldn't apply she would provide a hardship waiver, so that there would be no individuals under 100 percent of poverty that would be subject to that penalty. So the issue is that Medicaid is an important element of ACA financing. And while some of us knew this, it was never in writing anywhere until fairly recently, when the CBO noted that due to the Supreme Court decision it changes the financing a little bit, in terms of what the Congress had originally provided for and what exists now. So they could have picked any percent of poverty when they were deciding what part would be Medicaid and what part would be in the exchange. Part of the calculation had to do with the cost of the individuals likely to be in the exchange or in Medicaid. And there was a finding that the lower the income, the more likely that they had health issues. And that was part of the reason why their income was low. So that they were not in the work force due to behavioral health issues, substance abuse issues, chronic illness issues that kept them out of the work force and kept their incomes low. Now, there is a differential in what it costs to provide care to someone under Medicaid and under insurance in the exchange. The CBO has identified that differential to be $3,000 per person. So that to cover an individual in Medicaid is $6,000 and to cover someone in the exchange would be $9,000 because of the reimbursement rates primarily, the reimbursement rates that Medicaid

provides versus what is provided in the private market. So when you have more of the low-income people going into the exchange, that's going to change the federal expenditures for the exchange and will also have some impact on other aspects of the exchange. So this is something that is an issue. And the reason why there is a...certainly they would very much like to see a lot of states do that Medicaid expansion. So this slide here talks a little bit about the components of the universal coverage proposal. There's the individual mandate, which has been upheld. There are the American health insurance exchanges, which are currently being constructed; and it looks like most of them, at least in the beginning, will be federally facilitated. The large employers have an employer responsibility provision, which hasn't been talked about very much, but it is important. It's important in the context of the Medicaid expansion. For large employers, and these are employers with more than 50 full-time-equivalent employees, if you have...you're providing coverage and the premium is more than 9.5 percent of an employee's income, they are then able to go into the exchange for coverage because that is considered unaffordable. If that happens, then the employer pays a penalty for having that person in the exchange. Now, if under the...before the Supreme Court decision, someone with low income would have been eligible for Medicaid. So they would have been eligible for coverage and would not end up in the exchange. If the state does not do the Medicaid expansion, it exposes some of the large employers to this penalty, because those low-income employees would not be eligible for Medicaid. So they would not have affordable coverage available to them, and they would be able to go into the exchange. And then the employer would be subject to the penalty. So you will hear from your larger employers, I imagine, on this issue. [BRIEFING]

SENATOR CAMPBELL: Joy, just as a note, every year...and I think it's one of the senators, anyone of us, can request, but this committee certainly does receive it, a list of all of the companies in Nebraska with a large percentage of Medicaid among their employees. And while it's been fascinating information for us this year, it might mean a lot more, is that what you're saying to us? [BRIEFING]

JOY WILSON: That's what I'm saying. I'm saying I think you'll hear from them. And then the Medicaid expansion, of course--initially a mandatory expansion, now optional--was to cover most low-income people. And so here, the potential impacts of states opting out of the expansion is, one, higher premiums than the exchange. And, of course, we don't know how the exchange thing is going to work, and we don't know right now what the premiums are going to look like. But if the premiums get high, then people probably will take the chance on the penalties because the initial penalties under the Affordable Care Act are fairly modest. So that is one issue, the large employer issue that we talked about. Your hospitals are very concerned about uncompensated care. There is a plan in the...there's a provision in the Affordable Care Act to reduce federal Disproportionate Share Hospital payments, because they figure more people would be covered and uncompensated care would go down. So that provision still exists in the law even though the Medicaid expansion that was figured into that has now been changed. [BRIEFING]

SENATOR CAMPBELL: You have a question. Sure, go right ahead. [BRIEFING]

SENATOR GLOOR: Joy, I just...I've done this once already this morning; I'd like to do it again. I think it's important. Disproportionate share is an important component of this. Would you mind elaborating, from an educational standpoint... [BRIEFING]

JOY WILSON: Certainly. [BRIEFING]

SENATOR GLOOR: ...what that is and what that means. [BRIEFING]

JOY WILSON: Yes. These are payments that go to hospitals that have a disproportionate number of uninsured, Medicaid, and Medicare clients. So that they have a higher rate of...so they're getting lower reimbursement in general or no reimbursement in a lot of cases from the people who are uninsured, and yet they are

critically important to their communities. And so the federal government provides payments to those hospitals to offset that work that they're doing and not getting compensated for. Now, the assumption was that under the Affordable Care Act, which was providing coverage for more people, that uncompensated care would be significantly reduced. And so they've set into place a provision that would take a substantial amount of money out of the Disproportionate Share Hospital program, without specifying a formula. So we do not know how that reduction will be spread across the states and across hospitals. There are some guidelines, but the actual formula is left to the Secretary of HHS to determine. And there has been no public discussions of that formula, that I'm aware of. So...but that is something that's hanging out there that's important, and all the hospital executives are very concerned about it. Because if a substantial number of states do not go forward with the Medicaid expansion, a lot of their uncompensated care is going to remain, and yet their offsetting assistance from the federal government could be reduced. So... [BRIEFING]

SENATOR GLOOR: Thank you. [BRIEFING]

JOY WILSON: You're welcome. [BRIEFING]

SENATOR CAMPBELL: And as a follow-up, we do have a list of all of the hospitals across the state that that applies to. We can make that available. But it does go border to border in the state of Nebraska. It's not just your largest hospitals. [BRIEFING]

JOY WILSON: No. No. And it's critically important to even the hospitals that have low DSH, so they're getting a small amount; it's important to them. So I am sure you will hear from the hospitals about that. There is a provision in the Affordable Care Act that provides reinsurance and kind of a risk adjustment protection for the plans that are in the exchange. So let's say you've got ten plans in the exchange, and one of them, for whatever reason, gets the sickest and the poorest, and they're still getting uncompensated care, and nobody knows why and it's just how it happened. There's a

provision that would allow...it's kind of a collection from all the insurers, and then there's money that goes to the one who got the short straw. Now, it's a fixed amount of money in the law. So that they had made some assumptions about how big a pot was necessary. With the expansion for Medicaid being optional now and changing the whole dynamic of who's in the exchange, it may be that the reinsurance pool may be insufficient. We don't know yet, but that's something that if you talk to actuaries, they raise that as an issue that needs to be at least looked at. And then finally, of course, without the Medicaid expansion, it is difficult to get to universal coverage. My attempt at humor: the fiscal cliff; there we are, hanging. And the fiscal cliff is a very important part of this discussion because probably everything is on the table, including Medicaid. So I list here some of the Medicaid proposals that have been part of previous recent deficit reduction discussions. Provider taxes: I believe at least 48 states now have some form of a provider tax. And there are efforts to reduce the amount of funds states can raise through a provider tax, which would then mean you'd have to find another mechanism to raise your state's share for Medicaid match. We've already talked about the Disproportionate Share Hospital reductions. The President proposed something called the "blended matching rate," which sounds pretty innocuous; however, when you're talking about enhanced match at 100 percent, anything you blend with it puts you less than 100 percent, was my observation, which is not what I think states want. So we've asked. And so they said, well, what they would do, it's a simplification thing. It's so much easier if you only have one matching rate. So the CHIP, which is also an enhanced match...we put CHIP and Medicaid and anything we've enhanced Medicaid, which it seems to me would include the Affordable Care Act provisions, we somehow put that all together and come up with one rate. Now, we've never seen a formula on how that would be done, although we know they must exist because CBO has costed out several different blended matching rate proposals that net the federal government substantial savings, which means that costs us something. So I just say...we've asked them to take that off the table, and that we've never gotten a response on that. So as far as I'm concerned, it's still alive. And that is of concern. There are discussions from both Republicans and Democrats on the Hill about looking at entitlement reform, including

Medicaid reforms that would include discussions of Medicaid block grants and other kinds of major reforms. So with that on the table, it's hard to say how that would affect the Medicaid expansion program going forward. So I just think that's important to note. Also, there are federal discretionary programs that we'll be looking to be reduced. And there were some plans already in place with the assumption that every state was going to do a Medicaid expansion. It was felt that there was not as much need for programs such as the Ryan White AIDS assistance, the mental health and substance abuse block grant programs, and some other...maternal and child health programs because a lot of those clients would be covered under Medicaid or the exchange, assuming the Affordable Care Act as enacted. Now without the expansion, not so clear that they would want to substantially reduce funding in those programs, because those individuals would still be in need of care and would not have another area of coverage. So I think that's important, not discussed very often, but as they start talking about fiscal cliff, I think that's a place to watch as well. And then any...if they fail to reach agreement, they're saying that we may go into recession or have another economic downturn. The fiscal cliff is a very difficult issue, and we'll have to see what happens. But it affects either way, whether you expand or not. What they do in terms of addressing the fiscal cliff will be important to states. Other uncertainties: continued court challenges. There are a number of challenges to the Affordable Care Act still moving forward at different levels of court. The Supreme Court yesterday sent something back to an appellate court, and we think that may end up coming back, so we'll see. You know, that's going up and down. Congress can't decide exactly what they want to do. Some of them are saying, well, it's law and we should go forward; and some are saying, well, it's law and we should go forward, but we should defund it. And there's just a lot of uncertainty. And I suspect that when we get further along on addressing the fiscal cliff, some of that will sort itself out. But right now, I say it's so many moving parts and so little time: 2014 is like tomorrow, and there's still much to do. And while the picture on the exchanges is really clearing up, and we kind of know where most states are; there are very few undecided states in terms of whether they're going to do a state-based or a federally facilitated or the in-between partnership. On the Medicaid expansion, I'd say the picture

is hazy. There are very few states that have said they are definitely going forward. And most of those states that are planning to go forward had already done a substantial Medicaid coverage expansion, and so they're in a different spot than a lot of other states, in terms of how the expansion would affect them. They would get savings because some of that money is all state money that they're using to cover people. And so under the expansion, that would be federal or federally matched at an enhanced rate. So I think that's important. Now there are a lot of states that are interested in the expansion but not in the diving in, full body, on the deep end of the pool. What they'd like to do is put their toe in the water and see how it feels and to phase in the expansion, as opposed to doing it all in, all out. And this is where the statutory enhanced match makes a difference. So if you want to wait and see how things go, you might miss out on the 100 percent enhanced match. You might...if you wait three years, you miss the whole 100 percent thing and you come in at 90 percent. So because...unless there's a change in the statute, the enhanced match is what it is on the year that it is. So whatever year you come in, that's what you would get, unless there's a change. But in order to do a phase-in would probably require a change in statute. So it also has some...they have to figure out what the federal costs thing would be, which, you know, in a fiscal cliff discussion makes all things difficult. But there are a lot of states that are pushing for some sort of phase-in. And we've not...HHS has said they're looking at it, and they've not said much about it since that. [BRIEFING]

SENATOR CAMPBELL: Joy, before we go on, can I stop right there? [BRIEFING]

JOY WILSON: Yes. [BRIEFING]

SENATOR CAMPBELL: One of the questions that we get, and we think we're answering it correctly--I want to make sure we're answering it correctly--is that under Medicaid expansion, you would not have to provide a mirror image of your current state Medicaid plan, or you would? [BRIEFING]

JOY WILSON: Well, just a few days ago HHS put out a letter to the Medicaid directors on the benchmark plans. I have read that letter three times now. I'm not sure I get it. They are also planning to put out another guidance or a rule about how Medicaid and the essential benefit package match up. I'm still working on understanding exactly what they've said. It sounds to me that essentially Medicaid and the essential benefit package have to match up in some way, but it's not clear to me exactly what that means. So I have a lot of questions. I've read the letter; I know they're coming out with another guidance soon. We all hate that word "soon" in Washington, because that could be tomorrow or that could be six months from now. But soon they're going to come out with...and I think what we'd have to do is then compare what's in the additional guidance, which would be a proposed rule, and the letter to the Medicaid directors, and see where we're at. One thing that they didn't do that a lot of states wanted them to do was define "habilitative services." They punted that, and you guys are going to have to figure that out because they're not going to. They said that would be state defined. So I'm sure you will start hearing from interested entities about helping you with that. But in terms of...it would not have to be a mirror; they still say there's a lot of state flexibility. But then it said it has to match up with the essential benefit package, and I'm not quite sure how that all comes together, to be quite honest. [BRIEFING]

SENATOR CAMPBELL: Senator Gloor, you had a question. [BRIEFING]

SENATOR GLOOR: Well, it's probably an opportunity...and this is part commentary, part looking for your read on this also. Senator Campbell's question and your response points out part of the concern that exists out there, both, I think, in the general public and within, you know, legislators. That is, you used the term, "some of us would like to stick our toe in," as opposed to "jump in." I would use the metaphor, "some of us are concerned about expecting to jump into a pool that didn't have any water in it," because there are so many unknowns and so many questions out there, we don't know what we're getting into. And it's a terrible conundrum; it's a predicament when we're still waiting for rules and regs and interpretations and, as you pointed out, perhaps

additional rulings from the courts. What are we getting into? And it's a real, real challenge for me as I sit down and try and be educated. The more I read, the more questions I have. [BRIEFING]

JOY WILSON: Well, it's interesting, I have talked to my colleagues at HHS. And I said that legislators, I tell them we got this memo, and they say, well, that's interesting, but what's a memo? How does that...is that a rule? I said, well, no, it's not a rule, it's a memo; it's a bulletin. And they go, well, how does a bulletin compare to a rule? I said, well, in HHS-speak, it's kind of, sort of, a light rule. They're going, oh, God, no. (Laughter) We don't have that in our state. And I'm going, yeah, I know. But you should read these things because they're important, but they're not rules. And sometimes there's going to be a rule, and then sometimes there's just the memo or just the bulletin or just the Medicaid director letter. And, you know, it's certainly difficult to get legislators to focus on a bulletin or a memo, because does it have the force of law? Well, kind of, sort of. You know, there's no real answer for a lot of that. And the fact that we don't have rules in some really important areas is certainly complicating things and has made a lot of states wait, and I think reasonably so in some areas where you really need to know the details in order to make an informed decision. But I think that...so, for Thanksgiving, HHS gave us three proposed rules. I think they're getting our Christmas presents ready. And I suspect that by Christmastime we will have at least two more sets of rules out. So I think there's going to be a lot of rule making going on in the next few weeks, now that the election is over and they are very focused on implementing the Affordable Care Act. So two of the rules that they issued right before Thanksgiving have a 30-day comment period, ends on December 26; Merry Christmas, ho, ho, ho. And one has a 60-day comment period. But I expect that we're going to get a lot of guidance very soon, and then it'll be a question of trying to digest it and get questions answered about interpretation and that kind of thing. So we're in for a blast of rule making like we've probably never seen. [BRIEFING]

SENATOR GLOOR: And...but you made the comment that you understand that there

are some areas where states may want to wait. Do you happen to have a priority list that you could share with me of what those areas might be? [BRIEFING]

JOY WILSON: Well, let's see, I have heard, for the states that want to...that have decided that they're not going to do a state-based exchange, they are very interested in the rule on federally facilitated exchanges, which has not happened yet. One of the big rules that they rolled out before Thanksgiving was on the essential benefit package, which was one that quite a few states...since they had asked for states to say what they wanted to be their essential benefit package before they put out a guidance, some states refused to do it, because they said, well, we're not going to sign our name in blood and we don't even have rules yet. So that has come out. Those are...and they also did the one on insurance market reforms, which some states had been interested in. They still have the accreditation of the, well, I guess that's part...that's in one of them. Accrediting the plans, that's in the rate review rules. So they're getting to the ones. There is still no rule on the multistate plans; people are interested in that. So, I mean, there are some big ones still out there, but they're moving forward. And they are trying to...they also, in addition to bulletins and memos, they put out FAQs. And those are actually some of the most helpful things that HHS puts out, which...when people send them...e-mail them questions, they compile them into a document, FAQs. And oftentimes they do clarify issues that people have had with some of the other things they've put out. So we are getting flooded with memos, bulletins, FAQs, and rules; and I confess I have not gotten through all of them yet, but it's something I'll be working on. And, hopefully, between all of that information, it'll be enough to help states make some of the decisions that they're expected to make in the next few weeks and months. [BRIEFING]

SENATOR CAMPBELL: Joy, before we go on, it might be helpful, I think for all of us, could you define and amplify a little bit on habilitative care, so we have some idea what's being left to the states. [BRIEFING]

JOY WILSON: Right. Well, habilitative care has always been an area of difficulty because it...everybody...it's like the blind man and the elephant. Everybody has a different feel for what it means. And increasingly at the state level, habilitative services has been meshed with autism coverage. And as you...and this becomes terribly important in the essential benefit package arena because a lot of states that wanted to do autism mandates had not gotten that done before the whole Affordable Care Act essential benefit package provisions were set up. And, as you might recall, if a state enacted a...the essential benefit package covers existing state-mandated benefits, but it had to be in a plan that was in existence this year. So if a state adopts a mandate in the 2012 legislative session, it was not in a plan that was offered this year, that becomes an excess mandate that a state would have to offset the costs for in the exchange. So a lot of states are caught in that situation but would like to do something for autism coverage. And so the question then becomes, what is habilitative services anyway? And are there some things that are part of what is considered a package of coverage for children with autism spectrum disorders, or is that not? And in the bulletin that HHS put out back in December of last year, they didn't define habilitative services. And that has been a discussion point going forward. And so when the rule came out, I'm sure everybody went right to, let's see what they did on habilitative services. And they said, oh, that will be defined by the state, which was, you know, like a trick question. So that is still kind of sitting out there as an issue. And I don't know exactly how that's going to be resolved. And I don't know, I mean, they've asked states to comment on it as part of the proposed rules. So we'll see what they do with that going forward. But that's...it's not "rehabilitative" services, so you're not "rehabilitating" somebody. But what is habilitate; what are the bounds of "habilitation"? And that's kind of the question. [BRIEFING]

SENATOR CAMPBELL: Any other questions before we go on? Joy, I just want to go... [BRIEFING]

JOY WILSON: I mean, the rest of this is about, if you're looking at doing a Medicaid expansion, what are the kinds of information that you need to consider? And I've based

this on a document that the Robert Wood Johnson Foundation has put together, and just added a few items. But, basically, it gives you a schematic of what are the costs and what might be offsetting savings to look at as you go forward. And I think the important thing as you use consultants is to make sure that...because every state is different; there's no cookie-cutter thing you can do for each state. And when you're looking at offsetting savings, a lot of that has to do with programs that are particular to a state or a locality or some combination thereof or even some private or not-for-profit kinds of things going on. And you have to make sure that you're looking at that whole picture. And it's very important for legislators to understand how their Medicaid program is financed. It used to be simple; it's not anymore. And I think it's really important for legislators to understand, if you're using a provider tax, how that works and how any other provisions of the Affordable Care Act might impact some of that financing that you're using: you know, understanding the disproportionate share hospital program and how it affects your state, how much money that is, coming in, and, you know, what would be the impact if your hospitals lost different percents of that money. So it's really kind of looking at not what the other folks are doing, but your own picture: what does your picture look like in terms of being able to raise matching funds; who are your uninsured; who are your Medicaid eligibles but not enrolled? Are they sick people or are they young invincibles? You know, it matters. Where are they located in your state? A number of states have done some very interesting work with consultants looking at just that. I think Idaho did a tremendous study on who are their uninsured, who their likely new enrollees would be, where they are in the state, what kind of resources they have in the state, what resources are they currently using when they do use? Just kind of getting a picture of what the possible impacts could be. And I think that that's kind of the new studies that are being done. The first studies on the Medicaid expansion are how much would it cost the state. Now I think it's more a nuanced look at not only what would it cost, what are the possible savings and who are the people and where would they be in the state and what resources do we have to provide services to them. So that's a whole different look. But it's the kind of thing where you can then plan how to...where you need resources and then maybe how you get the resources to where you

might need them. And it also helps in terms of working with your exchange and building around how the exchange is going to work and where resources are for the networks in the exchange. So I see them as complementary, and there is certainly federal planning money out there that can help fund some of those...some of that research. An area that has gotten some attention but not a lot is that under the Medicaid expansion a number of incarcerated individuals would be Medicaid eligible. There is Medicaid coverage available for in-patient hospital care for incarcerated individuals if they're in a hospital for more than 24 hours. But that would require the state to then determine...if you have a Medicaid expansion, you'd have to make sure that they were already Medicaid eligible, then you suspend their eligibility during their incarceration, and you'd have to reactivate it if they became hospitalized. But for some states, they believe there's significant savings there despite the administrative cost of doing the eligibility for that population. So things like that, it's kind of taking that broad sweep, that broad look at all of the areas that might be impacted and then taking a look at how your state comes out. A lot of states are talking about the multiplier effect, and that's, you know, new jobs and more income. And that's...I call that fluffy. It's a little fluffy, but it's real. And it's certainly worth looking at, and I think a lot of states are taking some look at the multiplier effect and the, you know, the balance of that, what it might do. So that's this last part, is really kind of looking at just some of the provisions you might look at. I think the six factors are important. The cost of your newly eligibles. The cost of the currently not enrolled. Administrative costs; there is going to be some, and that's not matched at the 100 percent; that's matched at 50 percent for most things. It is very important to note that if you want to upgrade your Medicaid systems, now is the time to do that; it's 90/10 money. And let me say this, Louisiana has said no to everything except that 90/10 money. (Laughter) Okay. [BRIEFING]

SENATOR CAMPBELL: Note that, huh, Joy? [BRIEFING]

JOY WILSON: That's important, because that's a high-cost item, and it will make your whole system more efficient. And they are allowing, if your Medicaid system is

integrated with your TANF or other systems, they're not requiring cost allocation for the system part. Very important. [BRIEFING]

SENATOR CAMPBELL: Joy, just a minute. Senator Gloor. [BRIEFING]

SENATOR GLOOR: Short question. Does that include MMIS? [BRIEFING]

JOY WILSON: That would be MMIS. [BRIEFING]

SENATOR GLOOR: That, I mean, that...however that is defined, sometimes loosely. Do we think it'll be defined loosely? I want to know where my Medicaid dollars are going, anything related to that, how they're being expended. Anything related to that would fall under that 90/10, do you think? [BRIEFING]

JOY WILSON: Hmm. [BRIEFING]

SENATOR GLOOR: Again we're back... [BRIEFING]

JOY WILSON: Because of the way you're asking the question, I'm not going to say yes. I'm going to say maybe. But they can tell you, I mean, if you put it in front of them, they can tell you whether it's a yes or a no, I think. [BRIEFING]

SENATOR GLOOR: Okay. Yeah. All right. [BRIEFING]

JOY WILSON: Yeah, because everybody asks that question, and that's a really...that's a techie question. So I don't know. And every state's MMIS system is different and it has different appendages. But they are really... [BRIEFING]

SENATOR GLOOR: And some are nonexistent. [BRIEFING]

JOY WILSON: Well, there's that too. [BRIEFING]

SENATOR CAMPBELL: Or in great trouble. [BRIEFING]

JOY WILSON: Yeah. So...but they are trying...because it helps to have an up-to-date MMIS system to work with the exchange in the federal hub and all that goes with it. So...but that's very important. [BRIEFING]

SENATOR GLOOR: Thank you. [BRIEFING]

JOY WILSON: And then any savings from state programs and then other revenues and savings and...and, of course, the multiplier effect is always worth taking a look at. [BRIEFING]

SENATOR CAMPBELL: It will be interesting, I think, for all the senators, for us to receive the report. In our child welfare reforms, Joy, we put in for a consultant to look at Medicaid and how it all interacts with various programs. And we've also put in money for a consultant on IT. And so some of the reports that we receive from those efforts may give us some answers. Right now there's a number of us who would feel that our current MMIS system is average to poor. We know it needs to be updated. We have difficulty, you know, knowing, if you're in Medicaid and then what is the program...and no programs talk to each other. That goes back to Senator Gloor's question. I mean, if some of that money could be used to update our system now, that might be a great benefit to Nebraska. As a follow-up, on your questions on who are the uninsured and where they are located and what...in essence, you're saying there's a nuance, that there's a cost if you don't cover them under the expansion. And states are trying to get at that question. [BRIEFING]

JOY WILSON: There's that. And...and when you're...again, under this whole notion, you're talking about having resources to cover people in an expansion, which involves

both the exchanges and Medicaid. Most states feel that they are challenged facilitywise as well as work forcewise, and so it's important to know where you think the biggest impact is going to be and what your resources are in those areas. And having some idea of what you might need to do going down the road, in terms of assistance for training for work force or where you need additional facilities, where you need to maybe do telehealth or other things like that. You kind of have to know your people and where they are and what their needs are to best map out a strategy for moving forward to ensure that there's adequate coverage networkwise. And so it's important to have some of that information. I mean, I've seen some studies where they even talk about there's a lot of diabetes here, there's, you know, so that we need more resources to both do some, maybe, health education as well as to provide care for people. So that information has broad usage beyond whether you're going to do the Medicaid expansion or not. It helps you identify resource shortage needs and where you might focus different kinds of activities. But it's also important to know if you're doing a Medicaid expansion. [BRIEFING]

SENATOR CAMPBELL: One of the six bullets that you've noted is the savings from support from other state programs. People have begun to suggest some of the ways that that might be covered. And one of the questions that we've certainly directed to the counties is, how are these services now being provided through county general assistance; that if they were covered, is that a help to counties? And so it's just one example of what you're talking about in terms of the array of what happens in the state and serving that population. [BRIEFING]

JOY WILSON: That's right. And... [BRIEFING]

SENATOR CAMPBELL: There's a cost there. [BRIEFING]

JOY WILSON: And you know, there are a number of...there were a few counties that were offering county-covered medical assistance, across the country, and a lot of those

counties have stopped providing that because of their budget situations. And then there were a few states that had statewide coverage, Pennsylvania being one, who got rid of their general assistance health program just this last year. So the ability of state and local governments to have state- and local government-funded health programs has been really challenged during this economic downturn; and, you know, to the extent that they still exist, they're pretty much downsized. And...but they still exist, and some of them would free up funds at the local level in particular that would help them through this difficult economic situation. [BRIEFING]

SENATOR CAMPBELL: Joy, I want to go back...another topic. You touched on the foster care, and this committee had a hearing not long ago on foster kids aging out of the system and what age that should be and what services ought to be provided, and we alluded to this. On the foster child, that's any current or former, isn't that correct? [BRIEFING]

JOY WILSON: Yes. Yes. [BRIEFING]

SENATOR CAMPBELL: On the former? [BRIEFING]

JOY WILSON: Yes. [BRIEFING]

SENATOR CAMPBELL: But there is a time period that they had to have been in foster care to...as a former foster care. [BRIEFING]

JOY WILSON: Yes, and I don't remember that off the top of my head. [BRIEFING]

SENATOR CAMPBELL: I can't remember it. I think it's, like, 18 months to 2 years, or some...I mean, I don't... [BRIEFING]

JOY WILSON: I can't recall, but I can look that up for you. [BRIEFING]

SENATOR CAMPBELL: But the second point is there is not...and this is the question: Is there an income eligibility to any of that? So if I'm a former foster child and I'm, like, 23 years old, is there any income eligibility before you could access that? [BRIEFING]

JOY WILSON: I don't think there is, but I'm...I haven't looked at that lately. I'm not sure; I'd have to check. I'm not going to say... [BRIEFING]

MICHELLE CHAFFEE: It's a choice. [BRIEFING]

SENATOR CAMPBELL: It's a choice? [BRIEFING]

MICHELLE CHAFFEE: I think, at some point, there...some of the categories have, then, choices. They're able to look at the exchanges and the Medicaid and the traditional Medicaid, and they have the option to make a choice. And so part of why the essential benefits issue becomes an issue is where, as an individual would ask, where can I get the best coverage? And that is a cost driver. So how you set that up in regard to understanding that some of these categories, although they may not have to use MAGI, they may choose to make those choices. So I don't know if a foster care would be within that, given that they are traditionally unmarried, nonpregnant young adults. [BRIEFING]

JOY WILSON: Right. Yeah. And we don't have any rules on that either. So I don't know how they're going to...if they're going to be treated...except for the fact that they are former foster kids, would they be treated like other 26-year-olds or not, in other, you know, in terms of they're working and...I, you know, I don't know exactly how that would work. [BRIEFING]

SENATOR CAMPBELL: Healthcare for kids that are aging out of the foster care system is an identified need, at least from what we heard in the interim study. And I think it's something that many of us have known for a long time, but the public hearing for this

committee identified that. And so that's really helpful. [BRIEFING]

JOY WILSON: And I can get back to you; I can ask that question and see if they've got any clarifying information on how they would be treated. [BRIEFING]

SENATOR CAMPBELL: Given how we view aging out, that would be helpful. I want to go back to another...and I wrote notes as you went through, because I thought, well, we're going to get back to questions at some point. Are you saying that in January of 2014 is when the ban on how we could deal with eligibility in our current Medicaid program would be lifted, and we could make changes to our current plan? [BRIEFING]

JOY WILSON: You mean the maintenance of effort? [BRIEFING]

SENATOR CAMPBELL: Yes. [BRIEFING]

JOY WILSON: Yes, it goes off in 2014 when the exchanges go into effect. [BRIEFING]

SENATOR CAMPBELL: So, then, that's when we could make changes to our current... [BRIEFING]

JOY WILSON: Eligibility. [BRIEFING]

SENATOR CAMPBELL: ...eligibility. [BRIEFING]

JOY WILSON: But not for CHIP. [BRIEFING]

SENATOR CAMPBELL: But not for CHIP. [BRIEFING]

JOY WILSON: Right. [BRIEFING]

SENATOR CAMPBELL: Not for the kids. That's a very interesting point that probably...at least I'd not known that, because we've had to keep the current program... [BRIEFING]

JOY WILSON: In place. [BRIEFING]

SENATOR CAMPBELL: ...in place, not change it. And I'm sure the director will correct me if I'm wrong about that, but...other questions? I think what we'll...oh. [BRIEFING]

SENATOR GLOOR: Are we at a point of just general questions, or we're going to continue to...? [BRIEFING]

SENATOR CAMPBELL: I was going to take a short break, and we'll distribute cards, if people have questions, and then we'll come back and pick up some more questions, if that would be okay, Joy. How's that? Okay, how about if we take a five-minute break, and we'll make sure that cards are there for you to write your questions down. [BRIEFING]

BREAK

SENATOR CAMPBELL: I think we'll go ahead and start again. I want to remind you, if you have a question there are cards available and you can hand them to Michelle. So far we only have one person. I can't believe...get them up here. [BRIEFING]

SENATOR GLOOR: I'll make up for it. [BRIEFING]

SENATOR CAMPBELL: The committee always says they can tell when I...I get my teacher voice and...as we start and collect any of the cards and questions that you have, I want to remind all of the senators that yesterday we provided to your office digitally a copy of this. And I know some of you are working from this copy. But you

have the entire presentation that was sent to your offices yesterday. And for the newly elected senators, we'll ensure that you receive a copy, because Joy is just doing a great job. I was so...I had to chuckle when someone in the back of the room said, "I learned something today I didn't know." And that's...Joy, that's great, because obviously you're giving us a great background. The process from here on out is we've asked you to cover a little bit in the last six pages. And then Senator Gloor has a question. And then we'll go to the cards. So if you want to cover the last six pages, go right ahead. [BRIEFING]

JOY WILSON: I'm going to start with "Transition Savings," and these are, as you transition from the old to the new, in terms of the Affordable Care Act and the exchanges, there are some Medicaid programs that provide coverage to people who will wind up in the exchange, and you may then be able to get some savings or will be part of the Medicaid expansion and then you wouldn't need the extra program. And these are adults that are enrolled in various waiver programs. Some of them are on waiting lists because you were not able to provide coverage to them. Disease-specific coverage--this would include maybe breast and cervical cancer coverage under Medicaid where low-income women get their breast/cervical cancer tests; and they may end up being covered either through the exchange or the Medicaid expansion and you would need the extra program. Family planning services; medically needy spend-down; and a host of special programs that state and local governments have put in place over time for usually special populations within the state. So you have an opportunity to kind of take a look at your list of programs like that and maybe transition out as those people become eligible for alternative coverage. And then looking at state programs, in addition to state-only coverage programs and local government coverage programs, some states have their own uncompensated care programs, that are in addition to, that complement the federal. A lot of states spend substantial funds on behavioral health and substance abuse, and some of that would be covered as people end up in private coverage. State public health spending, you have to take a look at that and see to the extent that you're picking up people who are using various public health services that would now receive that coverage under insurance. State...we talked about inpatient

hospital care for prisoners and then other state and local programs, usually for special populations in a state. And in terms of revenue gains and savings and the multiplier effect, look at your provider taxes and how they work into your financing system; how you tax insurers; how you assess insurers. And that may be affected by funding for the exchanges as well because a lot of states are looking at fees on health plans to fund the exchanges. So you have to take a look at that. General business taxes and any other special taxes your state may have or any tax relief that your state might give to various entities that might be affected or could be affected or that you might want to change. The multiplier effect, of course, is...and there are various groups that have different formulas on how to determine the overall impact of a Medicaid expansion, looking at the funding that would go into the healthcare sector through employment of more health work force, for hospital payments and not having uncompensated care, growth in auxiliary industries related to healthcare, so if you've got more people covered, hospitals are buying more supplies and that kind of thing. So it's that when you have more people insured and more people getting care, how does that affect your economy and are those offsetting savings and new revenue coming in, how would that affect your overall formula for determining the overall cost of the Medicaid expansion? So different entities do the multiplier effect different ways. Most states that have had this done it shows that there's a very positive impact, but there are still state costs that are involved in expanding coverage. And so it's kind of a question of how far you're willing to go, you know, how much is too much? And that, of course, is a question only each state can answer within their own...looking at their own calculus and understanding that everything in all of these impact statements are a range. Could be from a low of this to a high of this because there's so much uncertainty in terms of the dynamics, including how many people will actually go into an exchange, how many will take the penalty, you know. We don't know the answer to those things because we don't have an exchange to look at, so we don't know what the premiums are going to be yet. So I think there is a lot of unknowns, and trying to predict human behavior is...if only we knew, if only we knew (laughter). So...but I think it's very helpful to go through the exercise and to see what the range looks like to see what your own state snapshot looks like as you move forward

and try to make some determinations about what you want to do as a state. And then in my final slides are my, again, trying to be a little humorous as we look in at states and their decision making on the Medicaid expansion. So I have the first state and it's two chairs, they're empty. There's the ocean out there. Obviously they're enjoying the water. They're the "dive in, it's great" group. And there are only a few states that have decided to take the dive and that's California, Connecticut, Massachusetts, Maryland, Oregon, Rhode Island, and Vermont have said they are definitely going forward with the expansion. Most of those states have already substantially expanded their Medicaid eligibility, and so some of that with state funds, and so there was clearly savings to be had from them on having a federal enhanced match to do some of that. And some of them had plans to move forward aggressively to cover more people and so this fits into that plan of moving forward. Vermont, of course, as you know, is trying to have universal coverage with a single payer and kind of using the ACA as a transition into that so. Then we have the "just wetting my feet" crowd and they're most states. They're studying their options, weighing cost and benefits, and seeking the counsel of a variety of experts to try to see just what it means to do this Medicaid expansion, what it would look like in their state. And then there's the "what's so great about the water? I feel the sand on...I like the feel of sand on my feet." And that would be Alabama, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Texas, and Virginia. And I saw this morning that I think Missouri has joined that group. They're planted firmly on the beach for now. And that's kind of where we are at this minute. And like I said, day to day the statistics on who's where changes as states make more decisions about how they want to move forward on either the expansion or the exchanges and some of the other things. [BRIEFING]

SENATOR CAMPBELL: Joy, I think the presentation has been just great. This is a commercial for everyone in the audience. This afternoon we will be joined by the Appropriations Committee to begin looking at the questions, asking the questions, on Medicaid expansion. And I think it will be extremely important to have our colleagues on Appropriations with the Health Committee because of your point about the number of

state programs that we are currently doing, and will we really...you know, how does that balance out? That's not an area that we've probably spent a lot of time in, but I thought you were wise to suggest that we take a look at that. And our colleagues on Appropriations will probably have the best view of that across the board so. And I thought also just a comment at the end, last week or I think it was last week or the last two weeks we had a hearing on our Health Care Cash Fund that we have from the tobacco settlement. Now those discussions become very important because how those programs may be covered someplace else. So lots of things are tying together, at least for the Health Committee, and then more questions arise. So we're going to go to the questions. Senator Gloor, you get to start us off. [BRIEFING]

SENATOR GLOOR: Thank you, Senator Campbell. And so I don't forget my manners, thanks again, Joy, for taking the time out of your busy schedule to come out here. This really has been beneficial and having copies of this to look at, and make notes on I'll add to my growing library of information about the Affordable Care Act. I would love to increase the number of people who had access to healthcare services covered in some way, shape, or form. But it's pretty common knowledge with my peers that I have real concerns about an expansion of the Medicaid program because, and that's an indelicate way of saying it. And so I've written down what my concern is by way of asking you a question. Enrolling more people without reforming the delivery system could push the healthcare system to the point of collapse. And you made reference to facilities. Do we have the facilities? Do we have the staffing, those trained practitioners to provide the care to this bolus of people that moves in to the delivery system? You've talked about how we propose to pay for it. We've talked about issues of who would be covered, who wouldn't be covered. But what you haven't talked about and I think the reason is because there's not a lot of discussion about it is, how are we going to change the healthcare delivery system? Because right now, and the concern about the cost associated with this is, we pay for the provision of services. We don't pay for good outcomes. Hypothetically if I have my appendix that grew back, every time it grew back it would be paid to be taken out again. And if I could will it back because I enjoy having

surgery--God knows I don't and I can speak to that--I would go in every year to have my appendix taken out. Other than affordable care organizations, I don't see anything in the law that really encourages helping states reform the healthcare delivery system. Some changes in Medicare in terms of paying for outcomes, I recognize and understand that. But it seems to me that the scope of change we're going to have to undertake here is pretty broad and we don't get much guidance from the Affordable Care Act about how we can do that. And because of that, I worry that we're going to be overwhelming our healthcare delivery system. [BRIEFING]

JOY WILSON: Well, I'm glad you asked that question because actually there's quite a bit going on in the states across the country on service delivery change. And some of that is being funded by provisions in the Affordable Care Act that are related to dual eligibles which, of course, is one of the areas where states spend the most money and where there's the least coordination within the federal government. You have two huge programs, Medicare and Medicaid, providing services to one individual and doing very little coordination. And one of the frustrations for the states is that Medicaid was doing a lot of the work and the savings would accrue to Medicare and we didn't get to share in that largess. And some of that is changing. Melanie Bella, who is in charge of that particular part of HHS, comes from the states. And this has been one of her big issues, and she's having a fine time now working with funding states to do some demonstrations on how to provide outcome-based care for dual eligibles and to allow states to share in savings that accrue to these better services. And they're young. These demos are pretty new so I don't think we know how it's going to come out, but clearly this is an area of great importance because we're going to have more dual eligibles. Our demographics tell us that, and we've really got to figure out a way to provide better care and more cost-effective care for that population because that is where the bulk of Medicaid money is spent. It's not on the moms and kids. It's on the dual eligibles and people with disabilities. And that's where we're not doing as well as we should. [BRIEFING]

SENATOR GLOOR: But would you say it's up to the states to take the initiative on this (inaudible) the opportunity for some dollars perhaps to be made available by the feds to move in this direction? [BRIEFING]

JOY WILSON: Well, I don't know if it's their role but they're doing it. And I have to say that this is kind of a national trend, not just on dual eligibles but... [BRIEFING]

SENATOR GLOOR: Oh, sure. [BRIEFING]

JOY WILSON: ...on the medical homes for the families, because people have figured out, surprise, surprise, if the whole family is getting care in one place, they get more...they do...they make the appointments, they come to the wellness. You know, they make it because everybody is going to the same place and it's organized. Legislators love the medical home concept. [BRIEFING]

SENATOR GLOOR: Yes, they do. [BRIEFING]

JOY WILSON: I just...and you can see that happening across the country. They're calling it different things, but it's all about coordinating and managing care and putting some outcomes measures on the providers. So they're trying to change reimbursement from how many procedures you do to how well you do what you do. And so I'm seeing some of that is...a lot of that is going on across the country. Many more states are doing managed care. And, of course, managed care doesn't save money unless it's done right. But I think the attempt now is to figure out how to get it right and to make it work. So I think there's a lot actually going on in the states because the recession has taught states Medicaid has to be managed. You've got to get it under control because it's such a big part of the state budget. And I think that legislators know a lot more about Medicaid than they've ever known, and it's made a difference in terms of how they look at what needs to be done. And they're not just looking at cutting things, but how do you change the program and make it a more effective program? So that's happening. Some

of it is happening with the help of Federal Demonstration Dollars, and some of it is happening internally in the state with work with providers to try and better manage the program because the providers see it makes sense for them to work in tandem with other providers to try to keep the program working. [BRIEFING]

SENATOR GLOOR: Well, I think... [BRIEFING]

JOY WILSON: So it's not the answer, but I think there is some movement in that area that has not been where states have been. [BRIEFING]

SENATOR GLOOR: We have medical home pilots in the state, and the department, to their credit, has taken the initiative as an expanding medical home within Medicaid populations. But I'd also tell you it's a very small subset of everybody covered. And expansion of it is going to take a lot more initiative than is currently out there, not just legislative but, you know, even within the department and even within the provider communities. And I just don't know that I'm comfortable that we're going to reform the delivery system as fast as we're going to be faced with the inevitability of increased enrollments and the expense that comes along with that. It's just my concern. I think the Affordable Care Act, three-legged stool. And I think the leg that's missing is the one of major reform of delivery system. I still do. [BRIEFING]

SENATOR CAMPBELL: Any other questions from the senators here? Senator Howard. [BRIEFING]

SENATOR HOWARD: Thank you, Senator Campbell. Just a clarification, and thank you for being such a good presenter. You really have an ability to have people understand this complicated information. You talked about the continued uncompensated care costs for hospitals. Does that include other facilities such as healthcare clinics or...that provide care but traditionally serve a population that may not have the resources to pay? [BRIEFING]

JOY WILSON: No. The DSH money goes primarily to hospitals. The community health centers which provide a lot of the care have their own separate funding through the federal government plus they have a special reimbursement rate that they get for the paying patients. But they don't get part of the DSH money. [BRIEFING]

SENATOR HOWARD: But they will be included in some form if they receive compensation. [BRIEFING]

JOY WILSON: Well, in the Affordable Care Act, the community health centers got a very large infusion of funding, I think with the hope that that would help expand some networks. [BRIEFING]

SENATOR HOWARD: Good. [BRIEFING]

JOY WILSON: Whether that's adequate or not I think...I don't know that we know. But there's been an expansion both for existing community health centers as well as for the construction of new community health centers. [BRIEFING]

SENATOR HOWARD: Well, I really appreciate that. I worked as a case manager for years with Health and Human Services, and the philosophy earlier was that the Medicaid coverage was actually better than insurance that a lot of people could afford to carry. And the opportunity to go to the emergency room when you were sick rather than when it was an emergency was expensive for all of us. So the healthcare clinics really meet an important need in the community, and I'm glad to see that that's being addressed to help them do more outreach. [BRIEFING]

JOY WILSON: Well, and a lot of states are looking for the clinics to play a new role with the exchanges, in that there are going to be a lot of new young people who maybe do shift work or work in restaurants and things like that, have unusual hours. And their

hope is that some of the health clinics and other ambulatory care facilities can be specialized to try to attract some of the new people who will be coming into insurance and have evening hours, weekend hours, things like that. So there's really a lot of states are looking for ambulatory care facilities to be triaged so that people don't go to the emergency room when they have an ear infection or things like that. So that's what some states are looking at in addition to the normal kinds of things that community health centers and ambulatory care facilities do currently. [BRIEFING]

SENATOR HOWARD: Thank you. [BRIEFING]

SENATOR CAMPBELL: Okay. Our first question is, please comment on the prescription drug coverage, the extent and the tiers and so forth, in both the expansion and an exchange. [BRIEFING]

JOY WILSON: Well, in the new rule that came out last week, they've expanded the drug coverage in the essential benefit package. And I don't know that I could tell you right off the top of my head the details of it. But it was an expansion over what was proposed in the bulletin from December of last year. It didn't go as far as a lot of advocates would have liked. It doesn't go as far as Medicare Part D, but is somewhere in-between and gives states some flexibility in terms of how they manage that. And it does...it specifically addresses whether states can impose a prior authorization and incentives for using generics; and you can. [BRIEFING]

SENATOR CAMPBELL: Okay. And our next question is, will Nebraska still have the option of defining habilitative services even though we will be under the federal-based exchange? [BRIEFING]

JOY WILSON: Yes. It's important to note that every state has the ability to determine the essential benefit for the state, regardless of whether they are going to have a state-based exchange or a federally facilitated or a partnership exchange. The essential

benefit package is determined by the state unless the state chooses not to address it, at which point then there is a default which would be the small group plan in your state with the most people in it I think is the easiest way to put it. So that if a state decides not to submit something--I think it's now December 14, I think--if you don't submit something for your essential benefits, then it would go to the default. Otherwise, the state picks and it includes...so a state could have picked a package that includes all of your existing state mandates or those that were in existence in a plan as of this year without having any additional cost to the state. Or you could have picked the most popular HMO plan. There were several options that were available to a state. You still have to meet the ten basic requirements that are in the statute, but you can do that in a number of different ways. There is a lot of flexibility in terms of picking the essential benefit package. It's important to note that the essential benefit package that's picked for this year is only good for 2014, 2015, 2016, and then it will be reviewed. So I suspect at that point that all state-mandated benefits will not be grandfathered, so that's something to think about as you move forward. [BRIEFING]

SENATOR CAMPBELL: I think one of the things is the initial proposal that the Governor sent in for Nebraska has been declined. And so I think part of the question that a number of us have is exactly what does that mean? Will we get to submit another option or, because we're under a state exchange, will we just be given the option? So I don't know that we know the answer to that for Nebraska yet. [BRIEFING]

JOY WILSON: Well, if it was declined, he still has until December 14 to submit something else or you get the default, which would be the smallest...the small group plan in your state that has the most enrollees. [BRIEFING]

SENATOR CAMPBELL: And no matter whether you're in a federal exchange or not, you still have the decision on Medicaid expansion. Is that correct? [BRIEFING]

JOY WILSON: That's correct. [BRIEFING]

SENATOR CAMPBELL: That was a question that was lingering this summer. Actually when we were at NCSL we talked about that. [BRIEFING]

JOY WILSON: And you can go in and you can go out at will. [BRIEFING]

SENATOR CAMPBELL: I think a lot of us learned that...earlier this morning someone said that that was emphasized at another meeting. Joy, I much appreciate, and I know I speak for the entire committee and for the audience, we very much appreciate your presentation today. We certainly can make the presentation available. All senators have it already and can review. You are a ready resource and we call you often. I know Michelle probably has you on speed dial. But thank you so much for coming, and I hope that you can stay for a little bit if there are individual questions. So thank you. [BRIEFING]

JOY WILSON: Thank you very much. (Applause) [BRIEFING]

SENATOR CAMPBELL: Not very many people get applause at a hearing, I want you to know that. That's pretty special. If you are sitting on this side of the room, you may wish to move to that side of the room. And Director Chaumont I know is here and we'll get ready and set up, so we have a couple of minutes. So if you're sitting over here and you want to see the screen, you may want to move. All right. I think we'll reconvene this morning's presentation. And my request to the director was to redo Medicaid 101 for us to give you a background in this. I think I have found when I talk to people in the community it's most misunderstood as to what is Medicaid, what is Medicare, and how does this actually work. And so I appreciate the director going through it again. We've done this before and it's been very helpful. So welcome and thank you. [BRIEFING]

VIVIANNE CHAUMONT: (Exhibit 2) Well, thanks for having me. Always a pleasure to come and give your Medicaid 101. And so first of all we're just going to start out with

why is Medicaid so important. And that chart that talks about all the General Fund expenditures in the state of Nebraska tells you why there's so much focus on Medicaid. As you can see, Medicaid is almost $700 million of state General Fund. And the only program bigger than that up there is public finance and K-12 education, which is why the Medicaid program is such a popular program among legislators and why it takes so much attention. So let's just start with the Medicaid overview and I know most of you are familiar with this. Medicaid was started by Congress in 1965, and it's Title XIX of the Social Security Act. It was adopted in Nebraska in 1965, and it's an entitlement program to provide medical assistance for needy children, pregnant women, the aged, and the disabled. The Children's Health Insurance Program, CHIP, is part of a much older program. It was established by Congress in 1997, adopted by Nebraska in 1998, and it's Title XXI of the Social Security Act. And it's a health insurance program for children whose family income is too high for the kids to qualify for Medicaid. So if they're Medicaid eligible, they cannot be CHIP eligible. Medicare versus Medicaid. So Medicare, a lot of people think that Medicaid is a typo for Medicare, but it's actually not. (Laughter) Medicare was also established by Congress in 1965 and it's Title XVIII of the Social Security Act. Medicaid is Title XIX; CHIP is Title XXI. Medicare is a national program that's consistent across the country. Medicaid is a statewide program that varies among states. Medicaid directors like to say "50 states, 1 Medicare program; 50 states, 50 Medicaid programs" and that's absolutely correct. Medicare is administered by the federal government completely, and funded by the federal government. Medicaid is administered by the state within federal rules and partially funded by the federal government. So Medicare eligibility is basically based on age or disability, and there are no income limitations. If you worked the 20 quarters or how many quarters it is and you have...and you're of a certain age or you're disabled, you are automatically...you get that. You don't need to do anything further. On the other hand, Medicaid eligibility is based on income and on resources. So Medicare is the primary payer of inpatient hospital services to the elderly, and Medicaid is the primary public payer of long-term care services in this country. Individuals can be eligible for both Medicare and Medicaid and they're called duals. And if you read anything having to do with healthcare these

days, there's a lot of discussion about duals. So Medicaid and CHIP are administered in what on good days is a federal/state partnership. The Centers for Medicare and Medicaid Services, CMS, is a federal agency charged with the administration of Medicaid and CHIP at the federal government within the federal Department of Health and Human Services. The state develops a state plan for Medicaid and one for CHIP, which have to be approved by CMS. And the state designates a single state Medicaid agency to be responsible for the state plans. So that state plan for Medicaid and for CHIP is basically the contract between the state and the federal government as to how the state is going to administer the program in order to qualify for federal funds. So if we don't administer the program according to the state plan, then we don't get the federal funds. So within federal guidelines, the state establishes its own eligibility criteria. The states determine the type, amount, duration, and scope of benefits. And the states set the rate of payment for services. But most of those things, actually all of those things have to be in a state plan that has to be approved by the federal government. Eligibility...so all of that is approved by CMS. If we comply with the state plan and all federal requirements, we're eligible for federal financial participation, FFP. And the FFP for each state is determined by each state's Federal Medical Assistance Percentage, the FMAP. And that Federal Medical Assistance Percentage is changed every year. In the last I think since I've been here, the federal match has gone down every single year. And that federal match is determined by some complicated formula that I couldn't begin to describe, but it has to do with the state's economics. So it's a good news/bad news type of thing. It's a good news because that means Nebraska's economy has been doing well. It's bad news because the Medicaid program then needs more General Fund because the feds aren't submitting as much. And so the FMAP for this fiscal year is 56 percent, and when I got here I think it was close to 60. And when you have a budget of the size of the Medicaid program, a 1 percent difference amounts to money. So when the federal match goes down even 1 percent, you'll see that in our budget request as a big chunk of money. States have...on the CHIP, they have the option to administer the CHIP program in three different ways. They can have a stand-alone CHIP program, which means that the CHIP program is basically an insurance policy that is run by the

state. Or they can do it as a Medicaid expansion, which is what Nebraska has; same rules as Medicaid, same benefit package as Medicaid. Pretty much the only difference is that to be CHIP eligible you cannot have insurance and you can have insurance to be Medicaid eligible, so...and you cannot be Medicaid eligible in order to be CHIP eligible. Or the states can have a stand-alone CHIP program along with a Medicaid expansion program. And as of July 19 of this year, Nebraska has a combination CHIP program because of the 599 CHIP program. That's a stand-alone program, but we run the rest of the program as a Medicaid expansion. So there's some big differences in how Medicaid and CHIP are funded. Medicaid is an open-ended entitlement program. No matter how much you spend, assuming that it's within the rules, the federal government gives you your 56 percent. CHIP, however, is a grant or allotment system. You have a certain amount of money that each state gets for CHIP, and if you run out of that money, then you run out of that money. In a state like Nebraska with a Medicaid expansion program, if you ran out of the CHIP allotment, it would mean that you had to use the Medicaid funds to cover the services. Nebraska's CHIP FMAP has also been going down since I've been here, and it's currently, this year, about 69 percent. So there's certain benefits that the Medicaid program has to cover. There's mandatory benefits and optional benefits. The federal government requires certain benefits that every state has to provide. And those are things like inpatient hospital, nursing homes, physicians. The states can put a limit on the mandatory service, but it will be closely scrutinized by the federal government, but you can do it and a lot of states do. The optional benefits are benefits that the state can choose to provide and get federal reimbursement for those services. And some examples of those are dental therapies and prosthetic devices. And the biggest example of an optional benefit, which I think is rather odd, is drugs. Drugs are actually an optional benefit covered by every single state because it doesn't make any sense not to cover drugs because everything else would spike. Because states are not required to have optional services, states can totally eliminate optional services or they can place limits on the optional services; and those limits are not as scrutinized by the federal government because the state has the choice of saying we're not covering it at all and they don't have to. So the basic rule of Medicaid eligibility in the current

program is that to be eligible you have to be a member of a group. Some groups are mandated by the federal government and some groups are optional. Kids up to certain poverty levels are mandated; pregnant women up to 133 percent of the federal poverty level are mandated; and there's a wide variety of groups that are mandated. So people receiving SSI benefits, for instance, if you get SSI you qualify for Medicaid. There are nonfinancial requirements and financial requirements associated with eligibility. So the nonfinancial requirements are things like state residency. You have to be a resident of the state of Nebraska in order to be eligible for Nebraska Medicaid. You have to be a citizen or a qualified alien. You have to have a Social Security number. And you have to assign your rights to medical support and payment to the state. So if you have insurance, say you have private insurance and you have Medicaid, you have to say that Medicaid...that your private insurance can pay your medical bills because Medicaid is always the payer of last resort. So there's categorical requirements then like you have to be aged, blind, or disabled; you have to be a pregnant woman; you have to be a kid; or you have to be the parent or caretaker of a child. So there's two broad areas of financial requirements and one of them is income. There's a maximum amount of income that a person can make--and it's based on the federal poverty level--and be eligible for Medicaid. So, for instance, pregnant women is 185 percent of the federal poverty level; for CHIP it's 200 percent; the child's family, 200 percent of the federal poverty level; and there's different percentages for different aged children. And there's a lot of different percentages. The resource requirements are the maximum amount of resources so a resource is something like cash in the bank or stocks and bonds or burial policies or any number of kind of things that a person can have and be eligible for Medicaid. An example is $2,000 for SSI. Children in Nebraska do not have resource qualifications and neither do pregnant women. So we have home and community-based services waivers, and these are the federal government's attempt to allow states some flexibility to deal with special populations so that there are services. A common rule of Medicaid is if you're going to have a benefit, everybody gets the same benefit. But if you waive that requirement and you say we're going to focus on this particular population and give them benefits that are not for everybody else, then you do that through a home and

community-based services waiver. So those are, for instance, assisted living is a service that we only give to people who are on a waiver. In order to qualify for a waiver, you have to meet the nursing facility level of care. And the idea is that we would have folks have the alternative to stay in home in the community as opposed to the nursing home because it is less expensive and usually preferred by the clients. So we have various waivers. The aged and disabled waiver and the brain injury waiver are administered by my division. Medicaid and long-term care and the developmentally disabled waivers are administered by Director Fenner in the Division of Developmental Disabilities. [BRIEFING]

SENATOR CAMPBELL: Director, would you clarify on the waivers are there so many slots? [BRIEFING]

VIVIANNE CHAUMONT: Yes. [BRIEFING]

SENATOR CAMPBELL: Is that...that is correct, isn't it? [BRIEFING]

VIVIANNE CHAUMONT: Yes. [BRIEFING]

SENATOR CAMPBELL: How is that determined? [BRIEFING]

VIVIANNE CHAUMONT: The state picks a number and it's usually associated with funding. We have in the aged and disabled and the brain injury waiver we have more slots than we have people. So if you don't...that's another thing that's different about a waiver in the Medicaid program if it was just straight Medicaid and you need a service, that's covered; you have to give...in a home and community-based services waiver, you can limit the state's number of people and then only those people can receive the specialized services. I believe that DD has...I think they have a waiting list, but there's no waiting list for the A&D waiver or the brain injury waiver. It's very common for states to have waiting lists on all their waivers. We don't. We don't in Nebraska so. One thing

about a home and community-based services waiver, the state has to prove that they are cost neutral so that you're not spending any more money on the waiver than you would have been in the community...in the institution. If you're spending more money in the waiver, then that violates the federal rules and you have to redo things. So there's what I just said. And allows the state to provide services that are not otherwise covered, like assisted living would be one such service. And the whole point is to keep people out of the institutions. The participants have to be provided a choice between institutional and home and community-based services. You can't say if somebody wants to go into a nursing home they get to go into a nursing home. If they meet the criteria for the HCBS and they meet the cost analysis, they get to pick which way they're going to go. And like I said, it has to be cost neutral. So another thing that we have been doing a lot of is managed care. And at-risk managed care is where we pay per member per month, and the company that we contract with is at risk for all services covered under the contract. As of July 1, 2012, we have at-risk managed care for physical health statewide. We have two contractors in the ten-county area around Omaha and Lincoln, that's Coventry and United. And we have two contractors in the other 83 counties and that is Coventry and Arbor Health, which is AmeriHealth Mercy in partnership with Blue Cross Blue Shield. So as of this fall, we will have at-risk managed care for behavioral health. The RFP is currently out and we should be I think getting responses and opening bids the first week in January so that we have ruined Christmas for many a behavioral health company. The next phase that we are looking at is going to at-risk managed care for long-term care services, and we are starting to work on that. This is what the Nebraska Medicaid program looked like in the last fiscal year. We had more than 237,000 eligible persons and spent $1.6 billion. When I got here in May of 2007, in probably 2007-08 we had 2,000 eligible persons...200,000, sorry. That would be a big bump. There's a budget buster...200,000...sorry...Medicaid clients. So you can see that with the downturn in the economy the Medicaid and CHIP clients have gone up. These are interesting numbers I think. The aged represent 7.5 percent of clients in the Medicaid program, but 21.3 percent of the costs. The disabled represent 15 percent of the Medicaid clients, and 44 percent of the costs. That's why it's so important that we start focusing on these

populations to manage their care better to get those costs under control. The ADC adults are 13.4 percent of the population and 10.7 percent of the cost, so you see that. That's because mostly people tend to be healthy. And then what a lot of people don't realize is that the large majority of Medicaid clients are kids--64.1 percent are kids. And thank goodness, kids are cheap. So they represent 23.6 percent of the costs because, as a large rule, Medicaid kids are like other kids--healthy; and so they don't have a lot of expenses. For ADC adults, probably the biggest expenditure that we have as a general rule is pregnancy. And Nebraska Medicaid pays for the delivery of about 43 percent of all babies born in the state of Nebraska. So we have I think with managed care curbed the costs for the ADC adults and children. Those are on managed care statewide, and now we need to start working on the other populations. And that's about all I had today on what the Medicaid program looks like today. [BRIEFING]

SENATOR CAMPBELL: One thing that we might want to mention, Director, is the Medicaid Reform Council report on your Web site yet? [BRIEFING]

VIVIANNE CHAUMONT: It's on. The draft is on the Web site. The final will get sent December 1 to the Medicaid Reform Council, the Governor, and the entire...and the Legislature I believe. [BRIEFING]

SENATOR CAMPBELL: Yes, yes. [BRIEFING]

VIVIANNE CHAUMONT: So...but I think that it looks pretty much the same. [BRIEFING]

SENATOR CAMPBELL: And I'd highly encourage people to take a look at it. I think it's a great window certainly for the Legislature to have an idea of where the money goes and some of the areas that the department is looking at in terms of our Medicaid program. I think given Medicaid 101, then the report really seems to make a lot more sense or at least it has for the committee because you kind of understand the background to it. So I would highly encourage people to take a look at that. Anything different about the report

that we should mention? [BRIEFING]

VIVIANNE CHAUMONT: No. I mean it's, sorry, trying to...the report just has in more detail where the money goes and what initiatives we are currently working on. I think this last report clearly shows the savings that we've received from managed care. The populations that are in managed care, their costs are going down, and we can see where the costs are going down when you look at obviously managed care premiums are going up and hospitals are going down, physicians are going down, because they're being paid by the managed care company. So I think we have seen a good savings from managed care. And the reason that I think managed care, if done correctly, people get the services that they need. It's not about depriving people of services that they need. It's about managing their care. And I think it's been successful, and I certainly hope that the behavioral health managed care, once we get that implemented in September, will do the same thing. And then I think the next frontier is, and the previous speaker talked about all of the states that are working on those populations, you can see from the numbers that that's where the bulk of expenditures are. And other states that have gone in that direction have experienced savings and have been able to shift. We keep trying to shift people from an institutional setting to a community setting because in most cases it's less expensive. And with what managed care has done in those states that do long-term managed care is help people stay in their homes so that the shift of the percentage of people in the institution as opposed to in the home has shifted so that more people are in the home, which results in savings, and it's a win-win for clients as well. [BRIEFING]

SENATOR CAMPBELL: Is that seen as much also in the rural parts of these states, Director, or is that more challenging? [BRIEFING]

VIVIANNE CHAUMONT: No. I think the states that have very successful long-term care programs are also states...it's sort of amazing. Most states, you know, you think about Nebraska being, you know, pretty urban in the east and then rural. But when you start

looking at states, most states are kind of the same. Colorado, there's Denver, and then, you know, it's pretty much rural. Arizona, which has a very successful long-term care program, is basically Phoenix and everybody else. And they have...and it has worked. And I think that, in fact, it might help rural communities to...because managed care companies have an interest in helping to set up different levels of care; and so that could actually help communities where they don't have as much community services to get them going. [BRIEFING]

SENATOR CAMPBELL: And part of the reason for that question is that we had an interim study hearing, a pretty lengthy one, this summer on long-term care facilities and how we've set that up in the state. So that's a very interesting component that we ought to keep in mind. This concludes our education briefing for the day and I want to thank the director for once again doing Medicaid 101. We will reconvene...(applause). Ah. I think, Director, you ought to mark this down as an unusual moment here. (Laughter) [BRIEFING]

SENATOR GLOOR: And one probably not repeated in the future. [BRIEFING]

SENATOR CAMPBELL: And as Senator Gloor said, probably one not repeated. (Laughter) But in any case, we very much appreciate that. I hope that helps to frame some issues for all of you that came today. We'll reconvene at 1:30 for the interim study, and I promise you a very interesting afternoon. [BRIEFING]