Healthcare Financing: Follow the Money

Teleconference hosted by the Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention
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Transcript

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After today's presentation, we will conduct a question and answer session.

To ask questions at that time, please press star 1. Today's conference is being recorded; if you have any objections, please disconnect at this time.

I would now like to turn the call over to Miss Paula Staley. Ma'am, you may begin.

Paula Staley: Thank you and good afternoon, everyone. We're really glad that you could join us today. My name is Paula Staley; I'm senior healthcare advisor here in the Office for State, Tribal, Local and Territorial Support at the Centers for Disease Control and Prevention.

I'm not Dr. Judy Monroe, who is the director of our office. She's unfortunately not able to join us for the start of this call; she may come in later. Actually, she's on another SIM-related call.

And so just so that you know, we had to divide and conquer today but OSTLTS is all in, as it were, on this initiative. We think it's just critically important.

It affects all of our health departments today. We are going to start off with this initial teleconference, talking about healthcare financing.

As you know, the healthcare system is undergoing a critical transformation. We feel that it's critically important for state health departments to understand the make-up of the delivery system, how it operates, and more importantly even than that, is how it's financed.

It's something that public health has not been up to speed on in the past, but with this statement, based on the model award from the innovation center at CMS, we have been provided with this unique window of opportunity.

But there is a sense of urgency. Folks need to understand this and get on board. So at CDC, one of the director's priorities for the next four years is the calibration or integration of clinical care in public health.

We have to find ways to work together to both improve health and lower costs. I think everyone in public health needs to understand that it really is about cost.

And we need to become very familiar with how healthcare is financed so we can begin to see where prevention and public health fit into that role.

But yes, these fields have very different cultures, public health and the healthcare system, and we also speak very different languages.

So the challenge here is finding the sweet spot where public health can impact the health system to lower the cost and improve health both in the short term and the long term.

We have to begin to understand that culture. We need to be able to speak the language—how healthcare is delivered and importantly as well, is how the money flows.

We have to understand what the health system needs, what they have, what public health has to bring to the table, and how to value that.

For example, community assessment, healthcare coordination, data analysis and evaluation, just to name a few. This training will be the first in a series on healthcare financing and delivery.

We have future planned topics on understanding health insurance markets, how healthcare is delivered, how the healthcare system is changing from fee for service to a more accountable, integrated community health model.

Also, understanding the value of public health services and what is that return on investment that the health system receives from those services.

We'll also provide examples and state specific resources in all of these teleconferences. So I would like to remind everyone that today's presentation can be found in the link, included in the invitation email that was sent to you today.

You can also download the presentation at http://www.cdc.gov/stltpublichealth/Program/transformation/index.html.

After the presentations today, there will be time for discussion in the last portion of the call. I encourage you to take advantage of this opportunity to share your thoughts and also to ask questions.

So without further ado, I'd like to introduce our speakers for today's call. Our first and main speaker is David Santana.

David works with the Office of Partnership Engagement at the Centers for Medicare and Medicaid Services. He'll give an overview of public sector healthcare financing programs.

Joining David is Dr. William Kassler, who's from the preventive care models group from the Centers for Medicare Medicaid Services. He is also chief medical advisor or officer at the New England Region Centers for Medicare and Medicaid Services.

Dr. Kassler will give examples of Medicaid waivers and other examples used by states, too, if they have public health initiatives that impact population health.

I'll now turn over the teleconference to David. David?

David Santana: Thank you so much and hello, everyone. Thank you once more for giving us the opportunity to participate in this call and give you a general overview of the programs that we oversee.

I think the objectives of this presentation are to give you a general sense of what population we serve here in CMS. This year we are expecting to have about 105 million people enroll in the three programs that we currently oversee.

But of course, these populations are about to grow because the Affordable Care Act and the upcoming health insurance marketplaces are to be functional

October 1 of this year; this is when enrollment is going to begin with the health insurance marketplaces.

And, of course, we are expecting that within the first year of the marketplace functioning, there may be about 8 million people enrolling through that venue in private health insurance plans as well as Medicaid and the children helping children's program.

As I hope that you have a copy of the slide presentation. As I go through, I'm going to mention the slide numbers so you can follow along.

So we're going to go on and start with Slide 2, which has the presentation division about three topics. The first topic is to give you a general overview about the Medicare program.

And then, we're going to go over Medicaid, a new eligibility group and lastly, we're going to go over some basic information about the children helping children's program.

Slide 3 goes into more detail about the Medicare program. The Medicare program, as well as the Medicaid program title 18 and Title 19 of the Social Security Act, was signed into law in 1965.

Back then, we only had about 19 million people enrolled in the Medicare program within the first year; today, we have over 51 million people enrolled in the Medicare program already.

As we all know, the baby boomer population started to come into the Medicare program; they started turning 65 back in 2011. According to the

census, we have about 78 million people who will be coming into the Medicare program.

And those were individuals who were born between 1946 and 1965. So we're going to have those folks coming into the Medicare program through 2025. If you do the numbers, we will have about four million people joining every year. That is about 11,000 every day, 450 every hour and, of course, 100 every 15 minutes.

I had an opportunity to go out and do a presentation with Social Security and Social Security is already feeling the impact across the country as their offices are being overwhelmed with individuals pouring in and trying to sign up for Medicare and ask questions, as they come to retirement age.

So, of course, that is another factor; our population is going to keep growing within the next 10 or 15 years to a very high number of individuals.

I'm going to move on to Slide 3. We're going to start talking about what is the Medicare program.

The Medicare program, as it was signed in 1965, was for only people who were 65 years of age and older; that was the simple program back in 1965.

In 1972, the Social Security Act was amended to include two additional groups of individuals; those who were disabled and receiving Social Security disability benefits or cash benefits and those who were diagnosed with end-stage renal disease.

When Medicare was signed into law, we were under the Social Security Administration. Up until 1977, the Healthcare Finance Administration was

created. That is what we call today the Centers for Medicare and Medicaid Services.

With that said, administration of the Medicare and Medicaid programs are under CMS purview; however, the Social Security administration is the agency better positioned to keep handling enrollment in the Medicare program.

They are one of our primary partners, helping individuals sign up for Medicare, so that's why they're pouring into Social Security with questions of enrollment and signing up for Medicare benefits.

I am going to move on to Slide 4. As the program was signed into law in 1965, we only had the two parts of the program, part A, which is hospital insurance, and part B, which is medical insurance.

Now in 1997, the DVA created what we called the Medicare post choice and today is called the Medicare advantage program. Congress created this Medicare post choice program to give individuals in Medicare the opportunity to get their healthcare delivered through a private health insurance plan.

In 2003, the Medicare prescription drug improvement and modernization act created the Medicare part D benefits or Medicare prescription drug coverage. That is to offer coverage through private health insurance companies for prescription drugs to individuals in the Medicare program.

So we have parts A, B, C, and D, concluding with the prescription drug benefits, which was the last law that added these benefits to individuals in Medicare.

Now Slide 4 goes into a little bit more detail in terms of what the Medicare part A hospital insurance entails. Most individuals will get Medicare part A at no premium.

That is because they or their spouse pay into the federal insurance contribution act, for at least 10 years, and they accumulated the required amount of quarters to get the Medicare part A at no additional premium.

Even individuals who do not have less than 10 years of coverage, for example, individuals who immigrate later to this country, or otherwise don't have any working history paying into the system, can purchase Medicare part A.

Of course, Medicare part A could be expensive. It is about $400 a month for individuals. If they want to purchase Medicare, nevertheless, individuals who do not otherwise qualify for free premiums, they could still purchase Medicare Part A and get it that way.

Slide 6 goes into detail in terms of the Medicare part A coverage for individuals who enroll in the Medicare program. Medicare part A mainly covers inpatient hospital stays. That will include semi-private rooms, meals, general nursing, and prescription drugs—pretty much everything that they get inside a hospital usually comes under Medicare part A.

Medicare also covers skilled nursing facility or rehabilitation care when the individual leaves the hospital. Of course, they have to meet certain requirements. For example, they have to be in the hospital for at least three consecutive days.

And if the rehabilitation care is as such that they needed to receive that care in an institution like 24 hour care, Medicare does cover for a skilled nursing facility to help them get back in shape.

Medicare part A also covers for home healthcare services if the individual, after leaving the hospital, can receive those services at home. We also pay for home healthcare.

We also pay for hospice for those individuals who are terminally ill and the doctors can testify that they have less than six months to live.

We do cover for hospice care as well as blood. Those are some of the general services that come under Medicare part A.

Slide 7 talks a little bit about the cost of Medicare part A to individuals. As you can tell, the majority of individuals qualify for premium three part A; in fact, about 99% of individuals on Medicare qualify for premium three part A.

Medicare is not an all-inclusive program. As you look at Slide 7, an individual has to incur out-of-pocket expenses as they receive the services. To understand how we calculate these services, we first have to understand what the benefits period is.

We divide the service and benefits period to calculate how much we pay, and how much the individual is responsible to pay. For example, a benefits period begins when the individuals becomes an inpatient at the hospital.

This ends when the person has been out of the hospital for longer than 60 days. There are an unlimited number of benefits periods if an individual goes

into the hospital and becomes an inpatient. We start counting from one day up to 60 days.

The individual has to pay an out-of-pocket deductible. This year, it's $1,184 that they have to pay out of pocket, and we pay everything else up to 60 days.

At any point during this time, if the individual gets out of the hospital, spends two months outside of the hospital, and comes back, these deductibles will reapply again. In the new benefits period, we begin every time the person has been out of the hospital and skilled nursing facility for at least 60 days.

So if the individual happens to be in the hospital longer than 60 days, from day 61 to day 90, they do have to pay a copayment per day of $296 out of pocket while Medicare covers the rest.

After 90 days, we go into what we call 60-day lifetime reserve date that individuals can use just one time during the lifetime. If they stay in the hospital from day 91 to 150, they have the option to use that 60 lifetime reserve days.

During that time, they are required to pay about half of the deductible, which is $292 per day, and we pay the rest.

Medicare part A stops after the individual has been in the hospital consecutively for 150 days. As you can see, it's not all inclusive after 150 days; the individual is responsible for all the charges.

Again, when that individual gets out of the hospital or skilled nursing facility and spends at least 60 days outside of the hospital, and they come back, these benefits appear will recycle again.

So again, this is giving you the general idea of how we go about paying for services, and how much the individual has to pay out of pocket for the service they receive under Medicare part A, if they happen to go into a hospital.

Slide 8 talks about the skilled nursing facility that we mentioned. As I said, Medicare does cover rehabilitation care in a skilled nursing facility if the individual has to be in an institution to receive those services and cannot receive it at home.

We pay everything for the first 20 days, from day 21 to day 100; the individual is responsible for paying a copayment of $148 a day. We pay the rest.

We stop paying after the individual has been in a skilled nursing facility for over 100 days. The individual is responsible for all costs thereafter. This will recycle again once the individual has been out of the hospital or skilled nursing facility for 60 days in a row.

Now let's move on to Slide 9 and quickly review Medicare part B coverage. As you can see, Medicare part B is mainly for doctor's services—services that are usually medically necessary, including outpatient.

Some doctors services they get when they're a hospital inpatient and, of course, they get covered preventive services. Outpatient medical and surgical services, that will move us to Slide 10, which is about home health services.

If an individual, for example, did not meet the three days stay in the hospital, they can receive the home health services through Medicare part B. If they

have not gone into the hospital, they go to their normal doctor and they set up physical therapy, occupational therapy, or speech language pathology.

They will go under Medicare part B services. Medicare part B, on Slide 11, also covers durable medical equipment, as well as other services that are medically necessary, such as clinical laboratory services, diuretic supplies, kidney dialysis supplies, mental health care, limited outpatient prescription drugs, diagnostic X-ray and so forth.

All these services are covered under the Medicare part B. Slide 12 goes into the number of preventive services that Medicare part B covers today. First, we have to welcome the Medicare exam, something that was added later on in 2007.

And then we also have the wellness exam that was added by the Affordable Care Act. Now individuals on Medicare, for the first time, can go to the doctor every year, every 12 months, and receive a wellness exam and Medicare will reimburse for this exam.

Then you have all the other preventive services. The majority of them are covered at no cost to the individual, meaning the deductibles and copayments do not apply to the majority of preventive services that come from the Medicare part B.

Those are the general coverage services of Medicare. We talked about the eligible population, three populations; those 65 and over; individuals who have certain disabilities, and those who, at any age, have end-stage renal disease.

Now let's move on to Slide 13 and talk about when can individuals enroll in Medicare part B? We give individuals generally three opportunities under which they can enroll in Medicare.

The first one is usually around the time that they turn 65. We give them seven months; three months before they turn 65, the month they turn 65, and three months after they turn 65.

So we give them seven months to go and enroll in Medicare. If the individual meets that initial enrollment period, we give them the opportunity to sign up every year from January 1 through March 31.

And that's what we call the general enrollment period in Medicare. However, if the individuals do not qualify for a special enrollment period, a 10% penalty is applied for every 12 months that went by that they could have had part B, but they decided not to enroll.

So again, these are the things that we stress to the individuals. The fact that if they decline Medicare when they're first eligible and they do not qualify for a special enrollment period, the 10% penalty will apply.

And there is no limit on that penalty. So if they wait five years, it's going to be 50% penalty and if they wait 10 years, it's going to be 100% penalty. If they wait 20 years, it's going to be 200% penalty.

The penalty will apply to whatever the premium is that year. So, if this year the premium is $104.90, if you have 200% penalty, it's going to be $104.90. If next year the premium is $200, it's going to be 200% penalty on $200, and so forth.

Now, there is also a special enrollment period. Of course, there are always exceptions to the rule.

There is a special enrollment period for individuals who have employer health coverage based on current employment—either through themselves or through a spouse or a family member if the person is disabled.

That means that when the individual is first eligible, if they have one of the employer plans that is based on current employment, they don't have to enroll in Medicare when they turn 65 or when they become entitled to Medicare due to disability.

Once that employer plan ends or they've retired, whichever comes first, they would have eight months special enrollment period to pick that Medicare part B without having to pay that penalty.

So they can apply that any time they have that employer plan or after the employer plan terminates. Then they have an eight-month special enrollment period to pick that part B without having to pay the penalty.

Slide 15 talks about the Medicare part B premium. In terms of how much does it cost for Medicare part B, actually we're going to back to Slide 14, skipping one slide.

So Slide 14 talks about paying for Medicare part B services. Usually, in Medicare Part B, you do have a deductible that you have to meet every year. Thereafter, Medicare usually pays 80% and you pay 20% out of pocket.

Slide 15 talks about the Medicare part B cost. Up until 2007, pretty much everybody paid the same premium for Medicare part B. The law changed then. Now it's based on the modified adjusted gross income of that individual.

So as you can see, an individual who makes more than $85,000 or a married couple who makes more than $170,000 will pay a little bit more on Medicare part B premium.

The way Social Security goes about determining how much you pay on your Medicare part B benefits, once you signed up, is that they look at your tax return from two years before.

You signed up for Medicare to determine your current Medicare part B premium.

If something has changed on the last two years of your tax return, or you have a more current tax return that you want to be taken into account because something has changed, you can always contact Social Security and make sure that that amount reflects the current situation.

So again, up until 2007, everybody paid the same. Thereafter, you can see that the Medicare part B premium is going to be based on where that individual falls within that income threshold.

Let's move on and talk a little bit about Medicare policy; that's on Slide 16. So we went over what Medicare part A covered and, more importantly, how the co-pay and structure works.

Meaning that Medicare is not an all-inclusive program, and of course, individuals have a lot of out of pocket expenses. If they happen to fall into the hospital for longer than 150 days, you can see that they could be on their own.

So that's where the Medicare policy comes in. Title 1882, or Section 1882, of the Social Security Act, set forth the requirements and the standards that covers or governs the sale of Medigap policies to people in Medicare.

So the Medigap policies are essentially private health insurance companies that are sold by individual providers to supplement Medicare; mainly to cover the services that we saw before in terms of the Medicare part A copayment, deductibles, Medicare part B coinsurance and deductibles as well.

So again, these policies are designed to cover those gaps in Medicare. They're not separate policies that individuals will have to cover what Medicare doesn't pay for, but rather to cover those gaps when Medicare does pay for services.

Slide 17 talks about the cause of those Medigap policies. Of course, the cause of the Medigap policy will vary by plan, the company and the location of that individual. It also can vary by the age of the individual; it depends on how they buy their policy.

Now these companies can only sell health insurance if they are part of the standardized Medigap policy called into law. On the next slide, we'll talk a little bit more about what the standardized policy means.

There are three states; Massachusetts, Minnesota, and Wisconsin, that are called the waiver states. They have their own type of supplemental policies. Although the coverage is pretty similar to the standardized policy, the structure is not the same.

One of the things that we tell the individuals is that these Medigap policies are not designed to work with Medicare advantage plans, meaning that if an individual has a Medicare advantage plan; it's illegal to sell them a Medigap policy because it's not going to work with Medicare advantage plan.

Some Medigap policies are what we call Medicare select policies; they're similar to an HMO policy in that they require individuals to go through certain providers to get the service paid for.

If they go outside, the company doesn't pay, but of course, with that restriction, the Medigap policy usually costs less.

Now the next slide, Slide 18, gives us a better picture of what the standardized Medigap policy means for individuals.

This allows individuals to make an easy comparison. You can see that there are letters in there, A, B, C, D, E, F, G up to M, and N. There are a group of core benefits that all Medigap policies have to offer when you move from hospice care coinsurance up. All the Medigap policies have to cover those core benefits.

It doesn't matter which policy you enroll in. It's going to cover hospice care coinsurance, blood, Medicare part B coinsurance and Medicare part A coinsurance up to an additional 365 days after the person stays in the hospital for 150 days.

So again, any Medigap policy that an individual signs up for will offer that additional protection, after the individual exhausts their stay in the hospital and the hospice, blood, and Medicare part B.

All these policies have the same coverage. If an individual says " I like to travel," for example. "I like to see a doctor who doesn't participate in Medicare." They are allowed to charge me up to an additional 15% over what Medicare part B allows for the services.

I may be looking at plan F or G, because if you look in their foreign travel emergency up to a plan amount as well as part B access charge, I'll call it by those two plans.

So if I know which plan I want, whether it's F or G, whichever company that is selling those plans where I live, I'm just going to look for the policy that gives me a better deal because the package and benefits will not change.

Again, this is to allow an individual easy comparison to go about purchasing the Medigap policies and help them pay for out-of-pocket expenses.

Now let's move on and talk about Medicare advantage plan. As I mentioned, the BBA of 1997 created these options to allow people in Medicare to get their healthcare delivered through the Medicare advantage plans.

We have about 25% of the Medicare population enrolled in the Medicare advantage plan. That is almost 13 million people enrolled in those programs today.

So we have quite a bit of individuals in Medicare getting their healthcare coverage through the Medicare advantage plan. Of course, for these companies to do business with the Medicare population, they have to be approved by CMS.

They have to submit a bid and be approved by CMS. As I mentioned, these are private companies. The way it works, when these plans get approval from CMS, we will pay these companies a certain amount of money every month to have these members enroll in the plan.

They take the risk that they're after to cover for hospital, Medicare part B services to those individuals. So this is basically another way to get Medicare coverage.

It is part of the Medicare program and on this plan, we'll know they could have a network or doctors or they could be any other type of organization such as a PPO that allows individuals to go outside the network.

That will take us to Slide 20, which tells us a little bit about what type of plans are offered to individuals in Medicare. As you can see, they're pretty similar to the products that are offered to the commercial market outside of Medicare.

They have HMO plans, they have PPOs, they have private fee for service plans, which is a combination of PPO plan with other options—meaning that these plans may not necessarily have network or providers. It depends on where they're operating).

An individual would have, for some of the doctors, accept these plans, terms and conditions. They can go to any plan or any doctor that will accept the plan.

We have a special needs plan; those are for special needs population, for example, individuals who are in Medicare and Medicaid, individuals who are otherwise institutionalized or individuals who have chronic conditions.

We also have health plans that offer coverage just to those individuals with special needs to better coordinate the care for these populations.

Paula Staley: David, this is Paula Staley. I just wanted to be mindful of the time, seems that you have about half the slides left to go through and we have how many more minutes?

Woman: About 12 to 13 more minutes.

Paula Staley: So we have about 13 more minutes, so want to make sure that we cover the Medicaid waivers.

David Santana: Definitely, thank you, Paula. So we're going to move on. These are the options for Medicare advantage plan.

Slide 21 gives us a general overview of Medicare prescription drug coverage. Again, these are private health insurance plans that offer prescription drug coverage to people in Medicare.

People in Medicare can get prescription drug plans through Medicare advantage plans or they could get it through a stand-alone prescription drug plan.

Slide 22 talks a little bit about the extra help; there is extra help for individuals for their prescription drug benefits. Some people who, for example, are in Medicaid getting supplemental security income.

They will automatically qualify for the extra help to get the prescription drug benefits. Slide 23 gives you a general overview of the income and resources

that individuals can have and still qualify for that low-income subsidy for Medicare to get the prescription drug benefit.

Slide 24 tells us a little bit about how individuals can go about getting the prescription drug benefits. I don't know how familiar everyone is with the donut hole or coverage gap, which under the Affordable Care Act, if you look at this slide, slowly is going to disappear.

Up until 2020, the plan will pay about 75% and the individual will pay about 25% out of pocket. So that coverage gap for the donut hole is aimed to disappear under the Affordable Care Act.

We're going to move on real quick to Slide 25, which is moving us closer to the Medicaid program. Slide 26 just gives you a little introduction of the Medicaid program, which is on the state finance program.

And that is assigned for people with limited income and resources and people with disabilities. Most costs from Medicare and Medicaid are covered by both programs but of course eligibility determination varies from state to state, as well as application process.

Now, under the Medicaid overview, usually the current rules or the previous rule in the Medicaid program, you have to be a member of a categorical group to be eligible for Medicaid.

For example, you have to be either a child, a pregnant woman, or the individual can be blind or disabled; those are the categorical groups. Also, they could be parents or caretakers of children.

Those are the mandatory categorical groups. If they are below a certain percentage of the federal poverty level, it's mandatory that the states will cover these groups to get the federal matching rates.

That takes us to Slide 27, which talks a little bit about the Medicaid waiver and, of course, Dr. Kassler will dip more into the Medicaid waivers.

But the waivers are just basically vehicles that states can use to test the new or existing ways to deliver health care in Medicaid under children's health insurance programs.

And, as you can see, there are four primary types of waivers and a demo project. One is the 915, the managed care waivers, the first one that states can apply to provide service to managed care delivered systems or other limits people choice and providers.

The second one is the home and community based waiver that the state can apply for. These waivers provide long-term care in home and community settings rather than institutional settings. This is designed to keep the individual living in the community rather than in an institution.

Of course, the famous 1115 waivers, states can apply for these waivers programs, and have the flexibility to test new and existing approaches to financial and delivering Medicaid and CHIP program.

And, of course, we do have the combination of the 915 BNC waivers that the state can apply to simultaneously implement two types of waivers to provide continuum of services.

And again, Dr. Kassler will dig a little bit more into what these waivers mean for the states. Now, real quick to Slide 28, which walks us through Medicaid savings programs; this is another segment of the population.

We have about 10.1 million people enrolled in Medicare and Medicaid today. Now, this population represents about 15% of the Medicaid population but they also represent about 40% of the Medicaid expenditures.

The Medicare they represent about 16%, about 27% of the Medicare expenditures. So aligning Medicare and Medicaid, probably Dr. Kassler may touch on this also, certainly will help improve the healthcare delivered to these populations.

And help the program by aligning these two programs will help save some waste and abuse in these programs because of the way that these programs will finance.

So who qualifies for Medicare savings programs? We do have about four categories of individuals; to look at the details in those four categories you can go to Slide 29. It tells you who is the qualified Medicare beneficiary, and what they look at to determine whether the individual qualifies for that.

If they do they get pretty much everything covered under Medicare part A and B. And the same goes for the specified low income Medicare beneficiary who gets help to pay for Medicare part B premiums.

Slide 30 talks about the qualified individuals, again individuals who fall under this category do get help to pay for part B premiums and also to qualify the several working individuals.

And you can see the eligibility categories in there, what the individuals can get. Now I'm going to move on to a Slide 31; it talks a little bit about the extension of Medicaid program in 2014 so I talk about the categorical groups of individuals have who likely qualify for Medicaid.

And how this is changing in 2014, to get a better picture of this additional group we're going to look at Slide 32; this additional group will be covered under the Medicaid program. Of course, this is up to the state option.

This is not mandatory, so they had the option to begin back in 2010 but full implementation is 2014. So who are these individuals? The new eligibility group includes individuals with income up to 133% of the federal poverty level which 5% is across the board.

Individuals under 65 who are not pregnant are not entitled to Medicare part A or enrolled in part B or any other mandatory groups, so that is the additional group that is coming to the Medicaid program in 2014. Again, this is up to the states.

Today we have about 27 states that support the Medicaid expansion. I think we have about four states that are still weighing their options, but that's where we stand in terms of the Medicaid expansion.

So on Slide 33, you can see the new eligibility group in a straightforward structure, four main categories of individuals: children, pregnant moms, parent and caretaker relatives, and the new adult group between the ages of 19 and 64.

The new group or the new roles in terms of Medicaid and chief eligibility is that the way that individual will be determined eligible for this program is going to be simplified.

There is going to be coordination with the new health insurance marketplace where individuals will fill out one streamlined application for all the insurance affordability programs.

So it has to be a coordinated effort between the marketplace as well as the Medicaid program. More importantly, if you look at Slide 34, it replaces the way that individuals are determined eligible for Medicaid and the amount to a modified adjusted gross income.

They're going to modernize eligibility verification and move to rely primarily on electronic data. It's going to be a federal hub of electronic information that the states can use to get information. We're going to be communicating with the Social Security Administration.

We're going to be communicating with Homeland Security and also we're going to be communicating with the IRS to get as much information as possible so they can rely on that primary electronic data to determine eligibility.

Renewals now for those who are determined under modified adjusted gross income are going to be no sooner than 12 months; they will not require face-to-face if they already have the information they need.

So again, the eligibility of redetermination is going to be primarily relying on electronic data.

Slide 35 talks about the streamlined application and how there's going to be coordination between Medicaid CHIP and the health insurance marketplace to make sure that there is no longer individuals applying for insurance affordability program.

Going to move on to Slide 37. It gives you a little bit of an overview of the CHIP programs that became law in 1997, as part of the BBA of 1997. It covers the nation on insured children when the parents were not low income enough to qualify for Medicaid but not rich enough that they could afford private health insurance on their own.

We're going to move on to Slide 39 which talks about who actually qualifies for the children's health insurance program. This is for children up to the age of 19, not already insured.

They have to meet certain requirements. As we all know, states set their own guidelines, and within federal rules to determine who qualifies for these programs.

There is a map on Slide 40 that gives you a general overview of how the CHIP program is run. They have an opportunity for a separate CHIP program or a Medicaid extension or a combination of both programs.

Slide 41 just digs down a little bit into eligibility, under the CHIPRA law of 2009. They changed a little bit how the individuals are determined eligible for the CHIP program.

The CHIPRA also, if you look at Slide 42, changes again the way that eligibility was determined for CHIP. They are able now to use express line agencies that will do a primary assessment and involve the individuals and

then the state will verify whether or not these individuals are actually eligible for the programs.

And that was a new way to go about determining who qualifies for the CHIP program. Slide 43 talks about the citizenship requirement that was also changed under CHIPRA, mainly allowing the states the opportunity to waive the five years rule that was put in place in 1996.

The personal responsibility and work opportunity reconciliation act, which placed that five year ban, under CHIPRA, allows for states to waive that five years for children and pregnant women.

We have about 25 states that have taken that approach to allow individuals who are legally residing here in the US, but do not have five years yet to get CHIP coverage through the CHIP program.

That concludes the general overview of what I have and I think I have about 4:23, so I'm going to go ahead and pass it over to Dr. Kassler.

Dr. William Kassler: Thank you very much, David. I'd like to thank my CDC colleagues; it's really a pleasure to share some thoughts with the state health officers.

Both CMS and CDC see Medicare and Medicaid as key partners in prevention and in population health efforts.

And it is an important focus of the innovation center state innovation model and clearly that's why all of you are here.

Our mission at the innovation center is to identify new models of service delivery and payment that improve healthcare, improve population health and, of course, reduce costs.

And we have a number of models at the innovation center that we're currently testing. Many of them are focused on finding ways to finance population health strategies that are delivered not only by clinical providers but by health departments and community-based organizations.

And so while my assignment today is to discuss Medicaid, I want to first note that CMS has a number of projects collaborating with states around Medicare in support of prevention and population health programs.

A couple of examples include several primary care initiatives in which Medicare has joined with ongoing state efforts for multi-payer medical home and other initiatives.

So as David explained, unlike Medicare, which is a federally run program, Medicaid and CHIP are financed jointly by the federal government and by states, and administered by states entirely but within federal rules. States have broad flexibility in how they run the Medicaid program; this results in considerable variation.

Waivers and demonstration projects, as David explained, are agreements between the feds and the state that exempt states from certain rules. This allows even further variation between states, and these waivers and demos have served as important incubators for innovation.

We've encouraged that. So it's not my intent this afternoon to discuss waivers per se, but to provide examples of a few select, and what I find very

interesting, state innovations that highlight the role that Medicaid can have in support of population strategies.

And the key glue here, the financing aspect, is that for covered services states get what we call an FFP or federal financial participation, which is often referred to as a match.

And the federal match ranges from 50% up to 90% for certain expenditures. So that's why states are looking to Medicaid to step in and to fund some of these population strategies because it's a way to get enhanced federal revenue.

So before I provide some examples, I'd like to offer a little bit of a contextual note. Medicaid covers 59 million people, it funds about a sixth of the total personal healthcare spending in the US.

It covers a quarter of US children, 8 million non-elderly with disabilities and another 1.3 million disabled children. And it is an important source of coverage for pregnant women.

Although not the major number of beneficiaries, the major expense for Medicaid is in nursing home and we cover about 60% of all nursing home residents, which is about 10 million individuals.

And then, lastly, we cover and provide extra assistance for low income Medicare beneficiaries through Medicaid. Premium assistance, cost shares, and services that Medicare either limits or excludes.

This population is sometimes referred to as the dually eligible or duals. And this is an important population because many have mental illness, substance abuse, are poor and disabled.

These are high-cost individuals, they're a vulnerable population, and they can be epidemiologically very significant as well.

So Medicaid is an entitlement program, and as such, as David explained, there are certain mandatory eligibility groups.

But there are also certain mandatory services. Perhaps you've heard the term EPSDT, for early and periodic screening diagnosis and treatment services.

These EPSDT are mandatory services for children age under 21, so age 20 and younger. And EPSDT is mandated and essentially covers most of what you would consider to be medically necessary services.

Not true for Medicaid adults, and we'll get to that in a little bit. But also you might not know that Medicaid mandates home health and certain transportation services as well as some family planning services.

But what I found interesting when I first learned about this is prescription drugs are an option. It's an option that all states choose to cover but there are also other optional services that the state can either choose or not choose to cover.

And these include personal care services and dental services for adults. So while dental services are covered by EPSDT, few states cover dental services for adults.

Prosthetic devices, eyeglasses, durable medical equipment, rehab, case management, hospice, and home- and community-based services are all optional at the discretion of the state.

I'd also like to note that Medicaid is counter-cyclical in terms of financing, which makes it a challenge for states to provide coverage and appropriate care within constrained resources during economically difficult times.

So by counter-cyclical, l I mean that the optional services and the optional populations are expanded in good times when states have money because states and its residents are generally altruistic and want to cover and provide these needs.

However, during economic downturns when the need for Medicaid is perhaps greater and enrollment does rise and states don't have a choice because they have to cover eligible populations, at this time when enrollment rises state tax revenues tend to decline.

And that puts a strain on budgets. And since Medicaid is the second largest budget item in most states after education, the optional services and the optional populations become targets for cuts as states try to balance their budget.

And so while certain features of the Affordable Care Act are intended to and likely will blunt the counter-cyclical nature, the structural aspects of Medicaid funding, and the fact that it's likely to be persistent in this counter- cyclical boom and bust.

I think as an aside it's important for public health officials to understand that the precarious nature of their Medicaid colleagues, often times it seems that compared to the scant funding for public health, Medicaid has so much money that they're flush, that a lot of money flows through the Medicaid program.

And I know that many state health officials on the public health side are frustrated when their concerns and priorities might not get the same traction within Medicaid.

But in spite of that seemingly large amount of money that flows through Medicaid in the face of state budget shortfalls, Medicaid often struggles to preserve the key services to the vulnerable population.

Services that may keep mentally ill individuals off the street—services that may keep elderly living independently in their home rather than going to a nursing home or services that provide access to a dentist for children and may make the difference between them being able to learn in school rather than being distracted by chronic pain from treatable dental abscesses.

So, with that note, I'd like to shift to again mention that states really vary widely in the amount and the scope of coverage's for preventive and population services.

And the state innovation model is really designed to allow you to collaborate across multiple sectors in terms of figuring some of this stuff out.

Here are a few examples, one of which is the breast feeding. We know that breastfeeding is an important public health intervention; we also know that states have very minimal requirements with regards to coverage of services.

Their obligation is to simply refer mothers to the WIC program. But there's no obligation to cover breast feeding education, individual consultations, or any equipment rental for pumping or anything else.

Two examples of states that have what we would call best practices in this area are New Hampshire, which covers a maternal post partum assessment and a wide range of lactation services for those found in need.

Florida, operating under a waiver that broadly coordinates prenatal care in a care coordination effort and then also provides in Medicaid funding for some of those optional services.

In Massachusetts, they have an asthma Medicaid waiver that's set to start this summer. That waiver will pay for a bundle of pediatric asthma services for high-risk patients.

And that bundle of paid services includes coverage of non-traditional home visits; these are non-clinical services that are delivered by community health workers.

They provide culturally and linguistically competent asthma education and case management that may be tailored to the needs and to the health literacy of the family.

Through these home visits and follow up services by nurses and community health workers, they end up being able to do environmental assessments in the home, environmental remediation, pay for HEPA vacuums, and pay for bedding encasements.

Integrated task management materials and professional pest control services when necessary, these are all again non-clinical services that are not reimbursable under a non-waiver fee for service type of situation.

They also reimburse a healthcare provider for a care coordination visit through a medical home. This again is a visit that does not necessarily have a face-to-face patient encounter and so wouldn't otherwise be covered.

In a pilot of children treated, they showed significant reductions in emergency department visits, hospital admissions, and improvements in the quality of life for children and their parents with dramatic results in just six months compared to demographically similar neighborhoods in Boston in which the program was not implemented.

The Michigan asthma program involves Medicaid managed care organizations as opposed to a fee for service type of situation. In Michigan, the Medicaid managed care organizations fund case management.

They reimburse for home visits, up to 18 visits, by a nurse or a community health worker. That visit also includes environmental assessment, patient education, some psycho-social interventions, and the provision of equipment like flow meters.

Managed care organizations reimburse providers for clinical care coordination in the context of a medical home. In Michigan, their evaluation showed decreased emergency department visit hospital days and shorter length of stay.

Of interest to me is that the Medicaid reimbursement for all these services still only covers about a third of the total cost of these programs. With hospitals and community based volunteers providing significant in-kind contribution. I think what this shows, that in order to do this stuff right, it takes more than simply paying for a few enhanced services.

But it really takes a multi-sector engagement. I think this shows a clear role for public health in the collaboration, and it also shows what level of resources in the community can be leveraged by such collaboration.

Along the same lines, with regards to Medicaid managed care, in New York, one major managed care organization covers both diabetes prevention and diabetes control programs that are different from what you would expect.

They cover the YMCA's diabetes prevention program, which as you know, follows the CDC-based diabetes prevention program. It's group-based, lifestyle interventions, it targets individuals who are at high risk for developing type 2 diabetes, and it does this through modest weight loss, healthy eating, increased physical activity, and other lifestyle changes.

The program that this managed care organization pays for is 16 sessions followed by monthly maintenance sessions for up to a year. The same managed care organization also funds the diabetes control program. That's a little bit novel in that they use select Rite Aid pharmacy branches in which they pay pharmacists to provide patient education to enrolled Medicaid beneficiaries.

This involves quarterly consultations to evaluate their medication adherence and to review the patient's blood pressure, glucose, and cholesterol lab results and then to counsel patients to supplement what goes on in the clinical environment.

For a number of years Tennessee has addressed their obesity problem by covering Weight Watchers® for Medicaid beneficiaries who have a BMI over 30. They pay for at a negotiated discount rate, initially 12 weeks of Weight Watchers sessions.

And for those beneficiaries who are able to attend at least 10 of those 12 weeks, they cover an additional 12 weeks. And the only cost to the beneficiary is a $1 copay at each weekly visit.

Tennessee observed that the cost of a 12-week program is equal to the cost of a month of a branded weight loss drug. I haven't seen any evaluation of that, but clearly this is something that represents a real population strategy.

Vermont, their program operates under a global waiver in which it is allowable for the state Medicaid program to apply the savings in cost for more efficient and coordinated clinical care to public health interventions that may not be strictly clinical.

This would not be covered under a non-waivered fee for service program, but are likely to improve health outcomes of the beneficiary.

So that's the standard, public health interventions that are likely to improve health outcomes. Vermont does a number of things, but one of the things that I want to highlight with this waiver is that they've used this authority to provide something that they call therapeutic daycare to a number of infants at risk.

In certain clinical and social circumstances where there's maternal substance abuse, maternal depression, DCYF involvement with other siblings that indicates abuse or neglect, a parental, usually dad incarceration, and almost always an overlay of severe poverty.

So in those situations, Medicaid would pay a negotiated rate for daycare level of services, that's daycare. And they considered this important to get the

infant out of the home during the day; we're not talking about taking the kids away.

But this improves the developmental trajectory of the infant. And this therapeutic daycare really consists of the various different services that one would expect of a normal childcare facility; to address the physical, emotional, cognitive, and social needs of a developing infant.

And again, clearly not covered under this; a state that wouldn't have this waiver. I'd like to end by going back to Massachusetts with their very successful smoking cessation program.

This highlights what a state Medicaid program can do in collaboration with public health without necessarily needing a waiver. I believe Massachusetts accomplished this all with a simple amendment to a state plan.

Their program involved covering all smoking cessation modalities, including individual and group counseling, and all pharmacologic interventions and eliminating structural barriers to the pharmacology, such as prior-offs and reducing co-pays.

So combining this, combining the benefits design, with aggressive outreach to both providers and to beneficiaries, again in collaboration with public health, Massachusetts noted significant increase in utilization, decrease in smoking and actually was able to demonstrate, within I believe two years, cost savings as well.

So I could go on at great length with a lot of different examples and I know many of you can cite equally compelling work in your own states. ASTHO is

collecting case stories and they've, I think, sent out forms to gather other interesting cases.

And I know my group within the innovation center has been looking to highlight population health strategies.

Many of the healthcare innovation awards contain population health programs and we're looking to see which ones are successful and might be able to be scaled up. We're looking at how to provide a sustainable funding stream.

And we're also looking for great things with the state innovation model in your own states. Thank you very much. I hope we've carved out enough time for some questions.

Paula Staley: All right, thank you so much for both those excellent presentations. We do have time here for some questions, so I'm not sure how people will ask them.

Woman: Operator, can you open the lines?

Coordinator: If you would like to ask a question please press star 1, to withdraw your question please press star 2. Again star 1 to ask a question; one moment.

Paula Staley: Well, I have a question while we're waiting on others to think of questions. Can you tell me, I think this is for David, about Medigap and the marketplaces? Is the Medigap going to be available? Is that one and the same?

Is that going to be available in the marketplace or how does that work?

David Santana: No, Medigap policies are not designed to work in the marketplace. The marketplace is for private health insurance plans, and they have to meet minimum standards to participate in the marketplace.

For example, offering essential health benefits, meeting certain out-of-pocket thresholds and another requirements under the public health service act.

Medigap programs are just designed to cover those gaps in the Medicare program, and they are not really under the same rules, in terms of the plans, to participate in the marketplace and outside of the marketplace. Meaning that they are excluded under the public health service act under those rules that they can add.

For example, they have the essential benefits, they have to have maximum out of pocket thresholds and things like that. So to buy a Medigap policy, an individual has to still buy it the traditional way.

Paula Staley: Thank you.

David Santana: You're welcome.

Paula: And I have another question. I guess we're still waiting for others to ask a question. This would be for Bill. Where can people get more information about the waiver programs, or how they might be utilized by the states?

Dr. William Kassler: I have two thoughts on this. First, CMS has a very vast, comprehensive, and challenging to navigate website in which we have probably more than you want to know.

But I would suggest that a state health official pick up the phone and call their colleague in their state Medicaid office.

The Medicaid medical directors, by and large, are a group of physicians that really understand and value population health and public health.

The Medicaid directors understand the ins and outs of the waiver process, but I don't want folks to get caught up on the legalities of: "Is it an 1115 waiver, a global, a state plan amendment, or the 1915 B?"

I think the best place to start is simply to form that relationship with your colleagues in Medicaid and discuss what you're trying to accomplish. The Medicaid folks in your state are going to be able to negotiate that complex maze of regulation.

Paula Staley: All right, thank you. I think we have a question, operator.

Coordinator: Yes, Tracy, your line is open.

Tracy Dolan: Hi, this is Tracy Dolan. I'm the deputy commissioner in Vermont, and I just wanted to speak briefly to the 1115 waiver that we have here in Vermont; it's been incredibly helpful to public health.

We've had a lot of flexibility. I think you heard the definition, which was broad enough to allow us to really apply the savings we get from Medicaid to public health programs that benefit Medicaid beneficiaries.

And so it's been really useful. And I think it's somewhat unique. I know that if anybody wanted to send me an email if there was enough interest, I might

be able to get somebody from our business office to speak a little bit more about how we use it here in the health department.

And from there maybe people could go further to understand how to negotiate that at a state level.

Woman: Thank you Tracy, appreciate that. Do you have an estimate of how much money that you were able to save in Medicaid that has been made available to public health?

Tracy Dolan: I don't have it in front of me and I can't say how much we've saved as a state, but I think for our department alone it's maybe $3 to $5 million in our department that we're able to apply toward public health.

I could be wrong on that, so don't quote me on that one.

Woman: I just wondered, ball-park kind of figure.

Paula Staley: All right, that sounds great. Thank you so much for your willingness to partner and offer information to people.

Dr. William Kassler: And I'd also like to say I think Vermont is a real leader and has done amazing things.

Paula Staley: Are there other questions?

Coordinator: As a reminder, please press star 1 to ask a question.

Paula Staley: Other states that were mentioned by Bill want to add anything to what he said, regarding the waivers?

Not hearing any more questions, I guess you all just blew everybody away. Everyone is in awe with what you're able to do. So I'd like to thank our speakers, David Santana and Dr. Bill Kassler.

I would encourage the folks on the phone to follow up with the resources that are made available. Also, if you would note at the end of David's slides, there was a listing of resources available to states.

Also, I encourage you to participate in our upcoming teleconferences. We're going to try to have one of these every three weeks, I think on Tuesday, and it would be at this time to follow up more in depth. The next one will be about the private health insurance market, how it operates.

How, with the new Medicaid expansion and the marketplaces, what those motivations will be in the private sector, then following up from there, more about healthcare delivery system moving from the 1.0 to 3.0; how it's been characterized from 1.0, which is a fee-for-service environment, to more of an accountable and integrated model.

With the patient-centered medical homes, accountable care organizations and then moving to where we are about now; moving to more of an integrated community health model, an accountable community, integrated community health model. And what that looks like and what the opportunities are for public health and population health in that environment.

Then from there, we'll move on to other sessions, which will talk more about how to measure population health and those metrics.

So anyway, I encourage folks to join us. Additional information will go out with the link.

If you have any other comments or there are any other topics that you'd like to see OSTLTS present, you can email your comments to OSTLTSfeedback@cdc.gov.

It's O-S-T-L-T-S feedback, and that's one word, and then @cdc.gov. I'd just like to take this opportunity again, if there's no further questions, to thank our presenters, all the folks who participated in today's call and our staff who set this up. Thank you so much. We'll talk to you soon. Good luck, thank you.

Coordinator: Thank you and this does conclude today's conference; please disconnect at this time.

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